Department of Defense funding of continuation of health benefits plan coverage for certain Reserves called or ordered to active duty and their dependents, and for other purposes.

S. 877

At the request of Mr. BURNS, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 877, a bill to regulate interstate commerce by imposing limitations and penalties on the transmission of unsolicited commercial electronic mail via the Internet.

S. 888

At the request of Mr. GREGG, the names of the Senator from Connecticut (Mr. LIEBERMAN), the Senator from California (Mrs. BOXER) and the Senator from New Jersey (Mr. CORZINE) were added as cosponsors of S. 888, a bill to reauthorize the Museum and Library Services Act, and for other purposes.

S. 893

At the request of Mr. SANTORUM, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 893, a bill to amend title VII of the Civil Rights Act of 1964 to establish provisions with respect to religious accommodation in employment, and for other purposes.

S. 923

At the request of Mr. KENNEDY, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 923, a bill to provide for additional weeks of temporary extended unemployment compensation, to provide for a program of temporary enhanced regular unemployment compensation, and for other purposes.

S. 949

At the request of Mr. JOHNSON, his name was added as a cosponsor of S. 949, a bill to establish a commission to assess the military facility structure of the United States overseas, and for other purposes.

S. 1000

At the request of Mr. GRAHAM of South Carolina, the names of the Senator from Georgia (Mr. CHAMBLISS) and the Senator from Massachusetts (Mr. KENNEDY) were added as cosponsors of S. 1000, a bill to amend title 10, United States Code, to revise the age and service requirements for eligibility to receive retired pay for non-regular service; to provide TRICARE eligibility for members of the Selected Reserve of the Ready Reserve and their families; to amend the Internal Revenue Code of 1986 to allow employers a credit against income tax with respect to employees who participate in the military reserve components and to allow a comparable credit for participating reserve component self-employed individuals, and for other purposes.

S. 1001

At the request of Mr. BIDEN, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 1001, a bill to make the protection of women and children who are affected by a complex humanitarian emergency a priority of the United States Government, and for other purposes.

S. 1009

At the request of Mr. BIDEN, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 1009, a bill to amend the Foreign Assistance Act of 1961 and the State Department Basic Authorities Act of 1956 to increase assistance to foreign countries seriously affected by HIV/AIDS, tuberculosis, and malaria, and for other purposes.

S. 1019

At the request of Mr. DEWINE, the name of the Senator from Virginia (Mr. ALLEN) was added as a cosponsor of S. 1019, a bill to amend titles 10 and 18, United States Code, to protect unborn victims of violence.

S. 1023

At the request of Mr. HATCH, the name of the Senator from Mississippi (Mr. LOTT) was added as a cosponsor of S. 1023, a bill to increase the annual salaries of justices and judges of the United States.

S. 1023

At the request of Mrs. FEINSTEIN, her name was added as a cosponsor of S. 1023, supra.

S. CON. RES. 21

At the request of Mr. BUNNING, the name of the Senator from Kentucky (Mr. MCCONNELL) was added as a cosponsor of S. Con. Res. 21, a concurrent resolution expressing the sense of the Congress that community inclusion and enhanced lives for individuals with mental retardation or other developmental disabilities is at serious risk because of the crisis in recruiting and retaining direct support professionals, which impedes the availability of a stable, quality direct support workforce.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. CANTWELL (for herself, Mr. CRAPO, Mrs. MURRY, Ms. MURKOWSKI, Mr. LEAHY, Mrs. CLINTON, and Mr. SCHUMER):

S. 1024. A bill to authorize the Attorney General to carry out a program, known as the Northern Border Prosecution Initiative, to provide funds to northern States to reimburse county and municipal governments for costs associated with certain criminal activities, and for other purposes; to the Committee on the Judiciary.

Ms. CANTWELL. Mr. President, today my colleagues and I introduce the Northern Border Prosecution Reimbursement Initiative. This bill outlines an important initiative that would give our northern border States and counties financial assistance in prosecuting criminal and immigration-related cases that arise because of proximity to the border. I thank my fellow northern border Senators and cosponsors, Senators CRAPO, MURRY, MURKOWSKI, LEAHY, CLINTON and SCHUMER for joining with me to introduce and work to pass this important legislation.

This initiative is modeled on a successful program already in place for southern border States. The Southern Border Prosecution Initiative allows States and counties to apply for reimbursement of costs incurred in any federally initiated or declined-referred criminal case. The program is targeted at immigration-related cases, but is not limited only to cases involving immigration charges. Cases arising out of immigration issues but ranging from a misdemeanor property charge to a felony drug conviction are eligible for reimbursement under the southern border program. The program proposed in the legislation introduced today would be operated in the same way.

Federal agencies—such as the Border Patrol and INS—have ongoing efforts to police the Nation's borders, resulting in hundreds of arrests each year. For many reasons, some of those cases are not pursued by Federal law enforcement authorities and instead are handed off to State or county officials for further prosecution. Instead of asking States to absorb those costs—likely at the expense of other important local law enforcement initiatives—the Northern Border Prosecution Reimbursement Initiative allows States and counties to receive compensation for pursuing these immigration-related cases.

The Northern Border Prosecution Reimbursement Initiative would be administered by the Department of Justice's Bureau of Justice Assistance. States and counties would be able to apply for reimbursement during an annual application period, with no limit on the number of cases submitted. Under the act, funds distribution is not based on the size or population of a northern border State, but upon the number of eligible cases submitted by each jurisdiction. It is possible for reimbursement to equal 100 percent of costs, though money is distributed on a pro rata basis if applications exceed available revenues. Each of the 14 States along the northern border would be eligible for the reimbursement program: Alaska, Idaho, Maine, Michigan, Minnesota, Montana, New Hampshire, New York, North Dakota, Ohio, Pennsylvania, Vermont, Washington and Wisconsin.

Last year, $40 million was provided to southern border States Arizona, California, New Mexico and Texas, offsetting the costs of prosecuting immigration-related cases. For 2002, $50 million was allocated to the program. My legislation simply authorizes $28 million for Fiscal Year 2004 be made available to northern border states for the same purpose.

In the years leading up to Sept. 11, 2001, activity along the northern border had shifted primarily from a focus on immigration issues to those related to

trade and commerce. However, homeland security has grown into a paramount concern in the wake of the 2001 terror attacks, and our States and local governments are increasingly bearing an unfair financial burden in protecting and patrolling our national borders. There are hundreds of crossings along the 4,000 mile long northern border between the United States and Canada, and though improvements have been made to tighten security, the northern border has yet to receive the resources it needs to adequately enforce our Nation's immigration laws and border restrictions.

The need for greater enforcement efforts along the northern border became glaringly evident in 1998 when Ahmed Ressam, a terrorist trained at one of Osama bin Laden's training camps in Afghanistan, was arrested shortly after crossing the Canadian border into Washington State. Explosives and other bomb-making materials were found in the trunk of Ressam's car. This frightening incident made clear the vulnerabilities we face along the porous northern border, vulnerabilities that became even more concerning after the Sept. 11, 2001, terror attacks.

In the last two years, the Senate has taken steps to improve northern border security. I have worked with Senators from the 14 States that comprise the northern border—including my colleagues who join me as cosponsors on this legislation today—and we have successfully devoted more resources to northern border security efforts. The 2001 Department of Defense Appropriation's bill included $55.8 million for 500 additional Immigration and Naturalization Service inspectors along the northern border—a 105 percent increase in staffing levels. That legislation also provided $23.9 million to transfer 100 border patrol agents and hire 100 new agents. Working to protect our northern border has been a bipartisan effort, enjoying cooperation from senators across the aisle and across the country. Now it is time to take another step toward greater border and national security and approve the Northern Border Prosecution Reimbursement Initiative.

The costs of homeland security are increasingly being borne by States and local governments, an issue that this legislation tackles head-on. Without giving States and counties the necessary resources to pay for cases initiated by Federal authorities, other important local law enforcement initiatives will undoubtedly be shortchanged. States and the Federal Government must work together if our borders are to be truly safe. The Northern Border Prosecution Reimbursement Initiative is a mechanism by which all of the resources of the criminal justice system—local, State, and Federal—can work in harmony.

Mr. SHELBY. Mr. President, I rise today to introduce the Older Americans Tax Fairness Act of 2003. My bill would completely eliminate the unjust taxation of Social Security benefits once and for all. The underlying premise of my legislation is simple: Social Security benefits were never intended to be taxed. At its inception and continuing on for the next fifty years, Social Security benefits were exempt from taxation. Budgetary shortfalls in 1984 and 1993, however, led to the taxation of these benefits.

Because of the rising cost of living, many of our seniors are forced to work past age 65. To these Americans, every penny counts in determining whether they are able to pay for food, heating, and healthcare. However, by taxing Social Security benefits, we make it increasingly impossible for millions of older Americans to make ends meet. In effect, then, taxation of Social Security benefits forces many Americans to endure stressful situations in what should be the golden years of their lives.

Taxation of Social Security benefits is also wrong because it changes the rules in the middle of the game. When seniors contributed to Social Security through the payment of payroll taxes, they did so with the understanding that they would one day receive those benefits tax-free. Unfortunately, because of runaway spending, many in the government have viewed Social Security taxation as a way to make up the shortfall between Federal spending and revenue. Such a decision was wrong then and it is even more wrong now as seniors face rising living costs.

In addition to being fundamentally unfair, I believe that taxing Social Security benefits once seniors pass certain income thresholds discourages them from working. I firmly believe that senior citizens add a wealth of knowledge and experience to the workplace. As such, we must make sure that our American workforce is not deprived of these valuable assets. Our laws should encourage older Americans with a desire to work to continue contributing to our society. Unfortunately, our laws do just the opposite.

Every year my office receives hundreds of letters and calls from older Americans throughout the country and Alabama describing the hardship that Social Security taxation has placed on their lives. The solution to this situation is simple—repeal the unfair taxation of these benefits. I therefore urge my colleagues to listen to their constituents and join me in support of my bill.

By Mr. ENSIGN:

S. 1029. A bill to enhance peace between the Israelis and Palestinians; to the Committee on Foreign Relations.

Mr. ENSIGN. Mr. President, I ask unanimous consent that the text of this bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1029

Be it enacted by the Senate and the House of Representatives of the United States in Congress assembled,

SEC. 1. SHORT TITLE.

This title may be cited as the ''Israeli-Palestinian Peace Enhancement Act of 2003''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The security of the State of Israel is a major and enduring national security interest of the United States.

(2) A lasting peace in the Middle East region can only take root in an atmosphere free of violence and terrorism.

(3) The Palestinian people have been ill-served by leaders who, by resorting to violence and terrorism to pursue their political objectives, have brought economic and personal hardship to their people and brought a halt to efforts seeking a negotiated settlement of the conflict.

(4) The United States has an interest in a Middle East in which two states, Israel and Palestine, will live side by side in peace and security.

(5) In his speech of June 24, 2002, and in other statements, President George W. Bush outlined a comprehensive vision of the possibilities of peace in the Middle East region following a change in Palestinian leadership.

(6) The Palestinian state must be a reformed, peaceful, and democratic state that abandons forever the use of terror.

(7) On April 29, 2003, the Palestinian Legislative Council confirmed in office, by a vote of 51 yeas, 18 nays, and 3 abstentions, the Palestinian Authority's first prime minister, Mahmoud Abbas (Abu Mazen), and his cabinet.

(8) In his remarks prior to the vote of the Palestinian Legislative Council, Mr. Abbas declared: ''The government will concentrate on the question of security . . . The unauthorized possession of weapons, with its direct threat to the security of the population, is a major concern that will be relentlessly addressed . . . There will be no other decision-making authority except for the Palestinian Authority.''.

(9) In those remarks, Mr. Abbas further stated: ''We denounce terrorism by any party and in all its forms both because of our religious and moral traditions and because we are convinced that such methods do not lend support to a just cause like ours but rather destroy it.''.

(10) Israel has repeatedly indicated its willingness to make painful concessions to achieve peace once there is a partner for peace on the Palestinian side.

SEC. 3. PURPOSES.

The purposes of this title are—

(1) to express the sense of Congress with respect to United States recognition of a Palestinian state; and

(2) to demonstrate United States willingness to provide substantial economic and humanitarian assistance, and to support large-scale multilateral assistance, after the Palestinians have achieved the reforms outlined by President Bush and have achieved peace with the State of Israel.

SEC. 4. SENSE OF CONGRESS.

It is the sense of Congress that—

(1) peace between Israel and the Palestinians cannot be negotiated until the Palestinian system of government has been transformed along the lines outlined in President Bush's June 24, 2002, speech;

(2) substantial United States and international economic assistance will be needed after the Palestinians have achieved the reforms described in section 620K(c)(2) of the Foreign Assistance Act of 1961 (as added by section 1506 of this Act) and have made a lasting and secure peace with Israel;

(3) the Palestinian people merit commendation on the confirmation of the Palestinian Authority's first prime minister, Mahmoud Abbas (Abu Mazen), and his cabinet;

(4) the new Palestinian administration urgently should take the necessary security-related steps to allow for implementation of a performance-based road map to resolve the Israeli-Palestinian conflict;

(5) the United States Administration should work vigorously toward the goal of two states living side-by-side in peace within secure and internationally-recognized boundaries free from threats or acts of force; and

(6) the United States has a vital national security interest in a permanent, comprehensive, and just resolution of the Arab-Israeli conflict, and particularly the Palestinian-Israeli conflict, based on the terms of United Nations Security Council Resolutions 242 and 338.

SEC. 5. RECOGNITION OF A PALESTINIAN STATE.

It is the sense of Congress that a Palestinian state should not be recognized by the United States until the President determines that—

(1) a new leadership of a Palestinian governing entity, not compromised by terrorism, has been elected and taken office; and

(2) the newly-elected Palestinian governing entity—

(A) has demonstrated a firm and tangible commitment to peaceful coexistence with the State of Israel and to ending anti-Israel incitement, including the cessation of all officially sanctioned or funded anti-Israel incitement;

(B) has taken appropriate measures to counter terrorism and terrorist financing in the West Bank and Gaza, including the dismantling of terrorist infrastructures and the confiscation of unlawful weaponry;

(C) has established a new Palestinian security entity that is fully cooperating with the appropriate Israeli security organizations;

(D) has achieved exclusive authority and responsibility for governing the national affairs of a Palestinian state, has taken effective steps to ensure democracy, the rule of law, and an independent judiciary, and has adopted other reforms ensuring transparent and accountable governance; and

(E) has taken effective steps to ensure that its education system promotes the acceptance of Israel's existence and of peace with Israel and actively discourages anti-Israel incitement.

SEC. 6. LIMITATION ON ASSISTANCE TO A PALESTINIAN STATE.

Chapter 1 of part III of the Foreign Assistance Act of 1961 (22 U.S.C. 2351 et seq.) is amended—

(1) by redesignating the second section 620G (as added by section 149 of Public Law 104–164 (110 Stat. 1436)) as section 620J; and

(2) by adding at the end the following new section:

"SEC. 620K. LIMITATION ON ASSISTANCE TO A PALESTINIAN STATE.

''(a) LIMITATION.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, assistance may be provided under this Act or any other provision of law to the government of a Palestinian state only during a period for which a certification described in subsection (c) is in effect. The limitation contained in the preceding sentence shall not apply (A) to humanitarian or development assistance that is provided through nongovernmental organizations for the benefit of the Palestinian people in the West Bank and Gaza, or (B) to assistance that is intended to reform the Palestinian Authority and affiliated institutions, or a newly elected Palestinian governing entity, in order to help meet the requirements contained in subparagraphs (A) through (H) of subsection (c)(2) or to address the matters described in subparagraphs (A) through (E) of section 1505(2) of the Israeli-Palestinian Peace Enhancement Act of 2003.

''(2) WAIVER.—The President may waive the limitation of the first sentence of paragraph (1) if the President determines and certifies to the Committee on International Relations of the House of Representatives and the Committee on Foreign Relations of the Senate that it is vital to the national interest of the United States to do so.

''(b) CONGRESSIONAL NOTIFICATION.—

''(1) IN GENERAL.—Assistance made available under this Act or any other provision of law to a Palestinian state may not be provided until 15 days after the date on which the President has provided notice thereof to the Committee on International Relations and the Committee on Appropriations of the House of Representatives and to the Committee on Foreign Relations and the Committee on Appropriations of the Senate in accordance with the procedures applicable to reprogramming notifications under section 634A(a) of this Act.

''(2) SUNSET.—Paragraph (1) shall cease to be effective beginning ten years after the date on which notice is first provided under such paragraph.

''(c) CERTIFICATION.—A certification described in this subsection is a certification transmitted by the President to Congress that—

''(1) a binding international peace agreement exists between Israel and the Palestinians that—

''(A) was freely signed by both parties;

''(B) guarantees both parties' commitment to a border between two states that constitutes a secure and internationally recognized boundary for both states, with no remaining territorial claims;

''(C) provides a permanent resolution for both Palestinian refugees and Jewish refugees from Arab countries; and

''(D) includes a renunciation of all remaining Palestinian claims against Israel through provisions that commit both sides to the ''end of the conflict''; and

''(2) the new Palestinian government—

''(A) has been democratically elected through free and fair elections, has exclusive authority and responsibility for governing the national affairs of the Palestinian state, and has achieved the reforms outlined by President Bush in his June 24, 2002, speech;

''(B) has completely renounced the use of violence against the State of Israel and its citizens, is vigorously attempting to prevent any acts of terrorism against Israel and its citizens, and punishes the perpetrators of such acts in a manner commensurate with their actions;

''(C) has dismantled, and terminated the funding of, any group within its territory that conducts terrorism against Israel;

''(D) is engaging in ongoing and extensive security cooperation with the State of Israel;

''(E) refrains from any officially sanctioned or funded statement or act designed to incite Palestinians or others against the State of Israel and its citizens;

''(F) has an elected leadership not compromised by terror;

''(G) is demilitarized; and

''(H) has no alliances or agreements that pose a threat to the security of the State of Israel.

''(d) RECERTIFICATIONS.—Not later than 90 days after the date on which the President transmits to Congress an initial certification under subsection (c), and every 6 months thereafter for the 10-year period beginning on the date of transmittal of such certification—

''(1) the President shall transmit to Congress a recertification that the requirements contained in subsection (c) are continuing to be met; or

''(2) if the President is unable to make such a recertification, the President shall transmit to Congress a report that contains the reasons therefor.

''(e) RULE OF CONSTRUCTION.—A certification under subsection (c) shall be deemed to be in effect beginning on the day after the last day of the 10-year period described in subsection (d) unless the President subsequently determines that the requirements contained in subsection (c) are no longer being met and the President transmits to Congress a report that contains the reasons therefor.''.

SEC. 7. AUTHORIZATION OF ASSISTANCE TO A PALESTINIAN STATE.

Chapter 1 of part III of the Foreign Assistance Act of 1961 (22 U.S.C. 2351 et seq.), as amended by section 1506, is further amended by adding at the end the following new section:

"SEC. 620L. AUTHORIZATION OF ASSISTANCE TO A PALESTINIAN STATE.

''(a) ASSISTANCE.—The President is authorized to provide assistance to a Palestinian state in accordance with the requirements of this section.

''(b) ACTIVITIES TO BE SUPPORTED.—Assistance provided under subsection (a) shall be used to support activities within a Palestinian state to substantially improve the economy and living conditions of the Palestinians by, among other things, providing for economic development in the West Bank and Gaza, continuing to promote democracy and the rule of law, developing water resources, assisting in security cooperation between Israelis and Palestinians, and helping with the compensation and rehabilitation of Palestinian refugees.

''(c) AUTHORIZATION OF APPROPRIATIONS.—Of the amounts made available to carry out chapter 4 of part II of this Act for a fiscal year, there are authorized to be appropriated to the President to carry out subsections (a) and (b) such sums as may be necessary for each such fiscal year.

''(d) COORDINATION OF INTERNATIONAL ASSISTANCE.—

''(1) IN GENERAL.—Beginning on the date on which the President transmits to Congress an initial certification under section 620K(c), the Secretary of State shall seek to convene one or more donors conferences to gain commitments from other countries, multilateral institutions, and nongovernmental organizations to provide economic assistance to Palestinians to ensure that such commitments to provide assistance are honored in a timely manner, to ensure that there is coordination of assistance among the United States and such other countries, multilateral institutions, and nongovernmental organizations, to ensure that the assistance provided to Palestinians is used for the purposes for which is was provided, and to ensure that other countries, multilateral institutions, and nongovernmental organizations do not provide assistance to Palestinians through entities that are designated as terrorist organizations under United States law.

''(2) REPORT.—Not later than 180 days after the date of the enactment of this section, and on an annual basis thereafter, the Secretary of State shall prepare and submit to the Committee on International Relations and the Committee on Appropriations of the House of Representatives and the Committee on Foreign Relations and the Committee on Appropriations of the Senate a report that describes the activities undertaken to meet the requirements of paragraph (1), including a description of amounts committed, and the amounts provided, to a Palestinian state or Palestinians during the reporting period by each country and organization.''.

By Mr. BINGAMAN:

S. 1030. A bill to expand the number of individuals and families with health

insurance coverage, and for other purposes; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, yesterday, I introduced the first part of a series of proposals to protect and strengthen our nation's health care safety net. That bill, the ''Strengthening Our States'' or SOS Act of 2003,'' seeks to protect and improve the Medicaid program—a critical component of our country's health system. To repeat the words of Diane Rowland and Jim Tallon of the Kaiser Commission on Medicaid and the Uninsured, ''Medicaid is the glue that helps hold our health system together and takes on the highest-risk, sickest, and most expensive populations from private insurance and Medicare.

Like a waterfront community that seeks to set up barricades against a rising river, defending the Medicaid program from attacks, such as the idea of a block grant, is a top priority.

However, once that is assured, we must also take the next step and confront the fact that an estimated 41.2 million people, or almost 15 percent of the population, was without health insurance during the entire year of 2001, which was an increase of 1.4 million people over 2000.

Moreover, the numbers in 2002 and this year have undoubtedly worsened. A report by the National Coalition on Health Care says, ''The confluence of powerful economic forces, fueled by the terrorist attacks on September 11, have unleashed a 'perfect storm' that could increase dramatically the number of uninsured in the U.S.—with as many as 6 million people in total losing their coverage in 2001 and 2002.''

The number in New Mexico are staggering. New Mexico leads or ranks second only to Texas in the percentage of its citizens who are uninsured. In fact, New Mexico is the only state in the country with less than half of its population having private health insurance coverage.

A rather shocking statistic, which also continues to worsen, is that one out of every three Hispanic citizens are uninsured. In fact, less than 43 percent of the Hispanic population now has employer-based coverage nationwide, which is in sharp comparison to the 68 percent of non-Hispanic whites who have employer-based coverage.

To address this growing crisis, I have worked closely with the American College of Physicians since last fall on the legislative proposal, which I call the ''Health Coverage, Affordability, Responsibility, and Equity Act'' or the ''HealthCARE Act of 2003.'' The proposal seeks to: First, build upon programs that currently work, including Medicaid, employer coverage, and the private market; second, provide choices for uninsured individuals, states, and small businesses while rejecting either employer or individual mandates; third, use methods that have bipartisan support by borrowing the best ideas from Democratic and Republican proposals; and, fourth, simplify rather than complicate coverage.

This is in sharp contrast, in a number of ways, to past efforts to create untried schemes or to impose mandates upon either businesses or the individual. It also seeks to bridge the divide between Democrats and Republicans. This has certainly not been easy to put together and nor will it be easy to pass. On the other hand, we have tried to start with the tools and principles more likely to get beyond the partisan divide.

As Julie Rovner of the National Journal recently wrote, ''If reforming the nation's healthcare system was easy, the old saw goes, it would have been done long ago. But for the moment, those who care about the issue seem to be succeeding only in butting each other's heads. Republicans keep pushing market-oriented reforms while Democrats want to expand existing public programs. And each party continues to reject the other's ideas. . . .''

The ''Health CARE Act'' seeks to break that partisan gridlock. First, it adopts and builds upon the notion of many Republicans to offer tax credits for the uninsured. As such, the bill would enact a new health insurance tax credit that is both refundable and advanceable to uninsured Americans with incomes up to 200 percent of the poverty level to purchase health coverage through a variety of options, including employer-coverage, State purchasing pools, or even the individual market—something pushed by a number of Republicans for many years but rejected by many Democrats.

Second, the legislation expands coverage through a State option with Federal financial support through the Medicaid program to anyone up to 100 percent of the poverty level. Medicaid has been a tried and tested program for low-income Americans over the years and is a far better and more viable option to people with incomes below the poverty level than a tax credit would be. Furthermore, few beneath the poverty level have the option of employer-coverage. Therefore, public programs, such as Medicaid, for low-income Americans makes far more sense than a tax credit.

Furthermore, through the strengthened and improved state purchasing pools provided for in the legislation, individuals and small businesses would be afforded better options to get coverage with a choice of plans that is typically not available to them with, what we believe will be, lower costs due to the ability to purchase coverage as a group.

Consequently, this approach attempts to build upon the ideas of both political parties, as it has both public program and tax credit aspects to it. Our hope is that people will see the things both parties like in it rather than focusing on what they do not like. In fact, we have also added the creation of an on-going expert health commission to make recommendations for further reforms and mid-course corrections in the future.

This bill is introduced in the spirit of compromise. To those on the right, I recognize your concern about the expansion of Medicaid as not being as market-oriented as you might prefer, but would point out that tax credits are virtually unworkable and employer-sponsored coverage often unavailable for people below the poverty level and that Medicaid is largely contracted out to private health plans—the same that many of you are enrolled in.

To those on the left, I recognize your concerns about tax credits and the potential for adverse selection with people buying coverage through the individual market, but I say to you that these are tax credits for low-income people and that we have taken steps in the legislation to mitigate problems that the added options in the bill create with respect to adverse selection. I would add that any expansion of coverage to people without health insurance is a good thing.

The most important message that I hope this bill carries is that we must stop having the perfect be the enemy of the good. This proposal is certainly not perfect but we hope it makes a very good start.

I would like to thank the American College of Physicians, or ACP, for their outstanding leadership and help in putting this legislation together. ACP has been a long-standing advocate for expanding health coverage and has authored landmark reports on the important role that health insurance has in reducing people's morbidity and mortality. In fact, to cite the conclusion of one of those studies, ''Lack of insurance contributes to the endangerment of the health of each uninsured American as well as the collective health of the nation.''

I would also like to thank the many people at the Economic and Social Research Institute, or ERSI, on their forethought, advice, and counsel as we refined the proposal over the past number of months. Their non-partisan approach and expertise have been invaluable to making the bill a workable and well-reasoned reality.

It should also be noted that the ideas put forth in the bill are based upon much of the expert work commissioned by ESRI, funded by the Robert Wood Johnson Foundation, and the Task Force on the Future of Health Insurance, funded by the Commonwealth Fund. As a result, the work of a number of other experts is reflected in the legislation and we thank you as well.

Among the endorsing organizations for this legislation are all of the leading primary care physician groups in our country. In addition to the American College of Physicians, the bill has been endorsed by the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Geriatrics Society.

As a practicing physician in New Mexico, Dr. Robert Strickland sums it up well. As he wrote in an editorial

published in the Albuquerque Journal about this legislation yesterday, ''As a New Mexico internist for 31 years, I have seen many uninsured people go without care until it is too late for me to do much to help them. The HealthCARE Act offers the potential of breaking the political gridlock that has allowed this crisis in health care to go on for far too long.''

I hope we can break the gridlock and urge my colleagues to heed the call of our nation's primary care doctors to support this legislation.

I would ask unanimous consent that letters of endorsement from the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Geriatrics Society, and Families USA, and the text of the legislation printed in the RECORD.

There being no ojection, the material was ordered to be printed in the RECORD, as follows:

AMERICAN COLLEGE OF PHYSICIANS,
Washington, DC, May 8, 2003.

Hon. JEFF BINGAMAN,
U.S. Senate, 703 Senate Hart Office Building, Washington, DC.

DEAR SENATOR BINGAMAN: on behalf of the American College of Physicians (ACP), I am pleased to express our strong support for the Health Coverage, Affordability, Responsibility and Equity Act of 2003 (HealthCARE Act of 2003). ACP is the largest medical specialty society in the United States, representing 115,000 doctors of internal medicine and medical students.

We very much appreciate the opportunity you have given us to translate many of the ideas in ACP's proposal to provide health insurance coverage to all Americans by the end of the decade into the HealthCARE Act of 2003. Specifically:

States will be given new options to extend health insurance coverage to low-income working Americans, without imposing unfunded mandates on financially strapped state treasuries.

Advance, refundable tax credits will be made available to uninsured working Americans with incomes up to 200 percent of the federal poverty level.

The tax credit will provide a premium subsidy equal to what the Federal Government now provides to its own employees.

Tax credit recipients will have the options of buying coverage through state purchase group arrangements modeled after the Federal Employees Health Benefits Program, giving them the same types and variety of health plan options now available only to federal employees, or from qualified non-group insurers.

Small employers will have new options for obtaining coverage, including having access to the variety and types of health plans offered to federal employees.

An expert advisory commission will recommend essential benefits that participating health plans will be encouraged to offer, as well as ways to expand coverage to those with incomes above 200 percent of the federal poverty level.

ACP is confident that this framework can succeed where other health reform proposals have failed. By offering incentives and choices to states, employers, and consumers, instead of ''one-size-fits-all'' government mandates, the HealthCARE Act has the potential of unifying, instead of dividing, key stakeholders.

The American College of Physicians commends you for your leadership in introducing the HealthCARE Act of 2003, and we look forward to working with you and lawmakers from both political parties in getting the bill enacted into law.

Sincerely,
MUNSEY S. WHEBY, MD, FACP,
President.

MAY 5, 2003.

The Hon. JEFF BINGAMAN,
U.S. Senate,
Washington, DC.

DEAR SENATOR BINGAMAN: On behalf of the 94,300 members of the American Academy of Family Physicians, I commend you for your outstanding leadership in the effort to assure access to health care for the uninsured in this nation. The AAFP has reviewed your draft legislation that would change Medicaid, SCHIP and the federal income tax code to make health coverage more affordable to uninsured Americans. I am pleased to inform you that the AAFP supports your bill and offers you our assistance in seeking its passage.

Your legislative proposal is a wide-ranging measure that would take us noticeably closer to affordable health care coverage for all. For example, your bill would:

assist states in creating purchasing pools to provide low-cost insurance for uninsured individuals with incomes up to 200 percent of the federal poverty level;

allow small businesses to have access to these state-operated purchasing pools so that they can offer affordable health insurance to their employees;

provide states with the new option to offer ''need-based'' eligibility for Medicaid beneficiaries;

remove the federal cap on non-waivered SCHIP coverage; and

offer federal income tax credits and premium subsidies for those currently uninsured whose income is at or below 200 percent of the federal poverty level and who are ineligible for Medicaid for SCHIP coverage or other insurance options.

These and other provisions of your proposal demonstrate your longstanding commitment to the health of everyone in this country and we are pleased and honored to support you in this effort.

Sincerely,
WARREN A. JONES, M.D., FAAFP,
Board Chair.

AMERICAN ACADEMY OF PEDIATRICS,
Washington, DC, May 7, 2003.

Hon. JEFF BINGAMAN,
U.S. Senate,
Washington, DC.

DEAR SENATOR BINGAMAN: On behalf of the 57,000 pediatrician members of the American Academy of Pediatrics (AAP), I write today in support of the Health Coverage, Affordability, Responsibility and Equity Act of 2003.

The problem of the uninsured and underinsured is real and growing. This legislation is an effective way to provide greater access to comprehensive health care for more Americans. This legislation would allow poor and near poor families a variety of options for affordable and comprehensive health coverage.

The Academy especially appreciates the effort to strengthen, not undermine current public programs. Currently, more than 9 million children are uninsured in this country and million more are uninsured for part of the year, churning on and off of health coverage. Seventy percent of the uninsured children are eligible for public programs but unenrolled. This legislation would encourage greater enrollment of these uninsured children by providing financial incentives to the states to enroll and retain these children, and by allowing families to unify their health coverage.

Thank you for your leadership and commitment to our nation's families and their access to quality health care. We look forward to our continued work together.

Sincerely,
E. STEPHEN EDWARDS, M.D.,
President.

AMERICAN GERIATRICS SOCIETY,
New York, NY, April 22, 2003.

Hon. Jeff Bingaman
U.S. Senate,
Washington, DC.

DEAR SENATOR BINGAMAN: The American Geriatrics Society (AGS), an organization of over 6,000 geriatricians and other health professionals who are specially trained in the management of care for frail, chronically ill older patients, is pleased to endorse the Health CARE Act of 2003. We commend you for your sponsorship of this important bill, which seeks to improve health coverage for millions of uninsured Americans.

By simplifying and expanding coverage choices for uninsured individuals and small businesses, your legislation represents a balanced approach to confronting one of our nation's most pressing problems. The consequences of having little or no health insurance are well documented. People without coverage are less likely to have a regular source of care, don't receive recommended health screening services nor do they have appropriate care management for chronic conditions. As a result, uninsured patients often are sicker and are more likely to die sooner than people who have health insurance. Adults in late middle age are especially susceptible to deteriorating health if they never had or lose their health insurance coverage.

The Health CARE Act of 2003 would improve the health of million of Americans expanding their access to health insurance coverage. AGS applauds your willingness to tackle this complex issue and looks forward to working with you to enact this bill.

Sincerely,
JERRY JOHNSON, MD,
President.

APRIL 28, 2003.

Hon. JEFF BINGAMAN,
U.S. Senate, 703 Hart Senate Office Building, Washington, DC 20510.

DEAR SENATOR BINGAMAN: Congratulations on your introduction of the HealthCARE Act of 2003. Your bill is an important initiative that seeks to combine good health policy with the politically achievable.

While Families USA, the national consumer health organization, has historically supported expansions of public programs like Medicaid and SCHIP, we recognize that different approaches are necessary if we are to see the enactment of major reductions in the number of uninsured. Your bill adroitly combines (1) a federally financed expansion of Medicaid and SCHIP to cover all those under 100 percent of the federal poverty level with (2) a premium subsidy/tax credit program to help those under 200 percent of poverty buy into various health insurance plans. Further, it lays the groundwork for an expansion of insurance to the rest of society by the end of the decade.

It is imperative that Congress act as soon as possible to help the nearly one our of three non-elderly Americans who are uninsured sometime during any two-year period. Federal help with Medicaid is particularly urgent to counter the massive cutbacks in coverage by the various states during the current economic downturn. As our recent report (''Going Without Health Insurance, Nearly One in Three Non-Elderly Americans'') shows, the problem of the uninsured,

and the adverse consequences of being uninsured, are much worse than previously reported. In your State of New Mexico, for example, 602,000 people—38.6 percent of the population under age 65—were uninsured sometime in 2002–2002. Of that number, 410,000 were uninsured for more than six months.

Your bill would make a major reduction in these unacceptable numbers. It would greatly improve the quality of health and security in America, and we look forward to working with you towards its enactment.

Sincerely,

RONALD F. POLLACK,
Executive Director.

S. 1030

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Coverage, Affordability, Responsibility, and Equity Act of 2003''or the ''HealthCARE Act of 2003''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—INCREASING HEALTH CARE COVERAGE

Subtitle A—Medicaid and SCHIP

SEC. 101. STATE OPTION TO OFFER MEDICAID COVERAGE BASED ON NEED.

(a) STATE OPTION.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) by striking ''or'' at the end of subclause (XVII);

(2) by adding ''or'' at the end of subclause (XVIII); and

(3) by adding at the end the following:

''(XIX) who are not otherwise eligible for medical assistance under this title and whose income does not exceed such income level as the State may establish, expressed as a percentage (not to exceed 100) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;''.

(b) INCREASED FMAP.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in the first sentence of subsection (b)—

(A) by striking ''and (4)'' and inserting ''(4)''; and

(B) by inserting before the period the following: '', and (5) in the case of a State that meets the conditions described in paragraph (1) of subsection (x), the Federal medical assistance percentage shall be equal to the need-based enhanced FMAP described in paragraph (2) of subsection (x)''; and

(2) by adding at the end the following:

''(x)(1) For purposes of clause (5) of the first sentence of subsection (b), the conditions described in this subsection are the following:

''(A) The State provides medical assistance to individuals described in subsection (a)(10)(A)(ii)(XIX).

''(B) The State uses streamlined enrollment and outreach measures to all individuals described in subparagraph (A) including—

''(i) the same application and retention procedures (such as 1-page enrollment forms and enrollment by mail) used by the majority of State programs under title XXI during the preceding year; and

''(ii) outreach efforts proportional in scope and reasonably expected effectiveness to those employed by the State during a comparable stage of implementation of the State's program under title XXI.

''(C) The State applies eligibility standards and methodologies under this title with respect to individuals residing in the State who have not attained age 65 that are not more restrictive (as determined under section 1902(a)(10)(C)(i)(III)) than the standards and methodologies that applied under this title with respect to such individuals as of July 1, 2003.

''(2)(A) For purposes of clause (5) of the first sentence of subsection (b), the need-based enhanced FMAP for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased, subject to subparagraph (B), by such percentage increase as would compensate all States for the additional expenditures that would be incurred by all States if the States were to provide medical assistance to all individuals whose income does not exceed 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved and who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XIX).

''(B) In the case of a State that provides medical assistance to individuals described in section 1902(a)(10)(A)(ii)(XIX) but limits such assistance to individuals with income at or below a percentage of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved that is less than 100, the Secretary shall reduce the need-based enhanced FMAP otherwise determined for the State under subparagraph (A) by a proportion based on the national income distribution of all individuals in all States who are (regardless of whether such individuals are enrolled under this title) eligible for medical assistance only on the basis of section 1902(a)(10)(A)(ii)(XIX).''.

(c) CONFORMING AMENDMENTS.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(1) by striking ''or'' at the end of clause (xii);

(2) by adding ''or'' at the end of clause (xiii); and

(3) by inserting after clause (xiii) the following:

''(xiv) individuals who are eligible for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XIX);''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2004, and apply to medical assistance provided on or after that date, without regard to whether final regulations to carry out such amendments have been promulgated by such date.

SEC. 102. STATE OPTION TO PROVIDE COVERAGE OF CHILDREN UNDER SCHIP IN EXCESS OF THE STATE'S ALLOTMENT.

(a) IN GENERAL.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 2111. STATE OPTION TO PROVIDE COVERAGE OF CHILDREN IN EXCESS OF THE STATE'S ALLOTMENT.

''(a) STATE OPTION.—In the case of a State that meets the condition described in subsection (b), the following shall apply:

''(1) Notwithstanding section 2105 and without regard to the State's allotment under section 2104, the Secretary shall pay the State an amount for each quarter equal to the enhanced FMAP of expenditures incurred in the quarter that are described in section 2105(a)(1).

''(2) The Secretary shall reduce the State's allotment under section 2104, for the first fiscal year for which the State amendment described in subsection (b) applies, and for each fiscal year thereafter, by an amount equal to the amount that the Secretary determines the State would have expended to provide child health assistance to targeted low-income children during that fiscal year if that State had not elected the State option to provide such assistance in accordance with this section.

''(3) Subsections (f) and (g) of section 2104 shall not apply to the State's reduced allotment (after the application of paragraph (2)).

''(b) CONDITION DESCRIBED.—For purposes of subsection (a), the condition described in this subsection is that the State has made an irrevocable election, through a plan amendment, to provide child health assistance to all targeted low-income children residing in the State (without regard to date of application for assistance) and to cover health services listed in the State plan whenever medically necessary.''.

(b) EFFECTIVE DATE.—The amendment made by this section takes effect on October 1, 2004, and apply to child health assistance provided on or after that date, without regard to whether final regulations to carry

out such amendment have been promulgated by such date.

Subtitle B—Refundable Tax Credit for Health Insurance Costs of Low-Income Individuals and Families

SEC. 111. CREDIT FOR HEALTH INSURANCE COSTS OF CERTAIN LOW-INCOME INDIVIDUALS.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 36 as section 37 and inserting after section 35 the following new section:

"SEC. 36. HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the applicable percentage of the amount paid by the taxpayer (or on behalf of the taxpayer) for coverage of the taxpayer or qualifying family members under qualified health insurance for eligible coverage months beginning in such taxable year.

''(b) APPLICABLE PERCENTAGE.—For purposes of this section—

''(1) IN GENERAL.—Subject to paragraph (2), the term 'applicable percentage' means the standard Government contribution (determined for full-time Federal employees enrolling in coverage for which such contribution is not limited by section 8906(b)(1) of title 5, United States Code) for an employee enrolled in a health benefits plan under chapter 89 of title 5, United States Code, for the calendar year in which the taxable year begins, expressed as a percentage of the total premium for such plan.

''(2) INCREASED PERCENTAGE FOR CERTAIN TAXPAYERS.—

''(A) IN GENERAL.—In the case of a taxpayer whose adjusted gross income for the preceding taxable year does not exceed 150 percent of the poverty level, the applicable percentage determined under paragraph (1) shall be increased by such percentage points as the Secretary determines will fully compensate such an individual for the individual's limited purchasing power in comparison to individuals whose adjusted gross income equals the average adjusted gross income for all Federal employees, to the extent that the amount of the resulting increase in the credit amount for all such eligible low-income individuals for the taxable year is not reasonably expected to exceed the 5 percentage point dollar amount for that year, as determined under subparagraph (B).

''(B) DETERMINATION OF 5 PERCENTAGE POINT DOLLAR AMOUNT.—For purposes of subparagraph (A), the 5 percentage point dollar amount for any taxable year is the product of—

''(i) the total number of individuals receiving credits under this section for such year, and

''(ii) the amount equal to 5 percent of the average health insurance premium amount to which such credits are applied.

''(C) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed to prevent the Secretary from establishing more than 1 level of supplemental assistance that provides greater assistance to individuals with lower income, determined as a percentage of poverty.

''(3) APPLICATION OF FEHBP COVERAGE CATEGORIES TO DETERMINATION OF CREDIT.—The percentages described in paragraphs (1) and (2) shall be applied to a taxpayer consistent with the coverage categories (such as self or family coverage) applied with respect to a health benefits plan under chapter 89 of title 5, United States Code.

''(c) MAXIMUM PREMIUM AMOUNT.—The amount paid for qualified health insurance taken into account under subsection (a) for any taxable year shall not exceed an amount equal to the capped premium established for the applicable State under section 204(c)(10) of the Health Coverage, Affordability, Responsibility, and Equity Act of 2003 for the calendar year in which the such taxable year begins.

''(d) ELIGIBLE COVERAGE MONTH.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible coverage month' means any month if during such month the taxpayer or a qualifying family member—

''(A) is an eligible low-income individual,

''(B) is covered by qualified health insurance, the premium for which is paid by the taxpayer (or on behalf of the taxpayer),

''(C) does not have other specified coverage, and

''(D) is not imprisoned under Federal, State, or local authority.

''(2) JOINT RETURNS.—In the case of a joint return, the requirement of paragraph (1)(A) shall be treated as met with respect to any month if at least 1 spouse satisfies such requirement.

''(e) ELIGIBLE LOW-INCOME INDIVIDUAL.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible low-income individual' means an individual—

''(A) who has not attained age 65,

''(B) whose adjusted gross income does not exceed 200 percent of the poverty level,

''(C) who is ineligible for the medicaid program or the State children's health insurance program under title XIX or XXI of the Social Security Act (other than under section 1928 of such Act),

''(D) who has limited access to health insurance coverage through the employer of the individual or a member of the individual's family (either because the employer does not offer such coverage to the individual or because the employee contribution for such coverage would exceed an amount equal to 5 percent of the household income of such individual, as determined in accordance with paragraph (2)),

''(E) who applies for a credit under this section not later than 60 days after receiving notice of potential eligibility for such credit, under procedures established by the Secretary, and

''(F) who resides in a State where the eligibility standards and methodologies applied under the medicaid and State children's health insurance programs with respect to individuals residing in the State who have not attained age 65 are not more restrictive (as determined under section 1902(a)(10)(C)(i)(III) of the Social Security Act) than the standards and methodologies that applied under such programs with respect to such individuals as of July 1, 2003.

''(2) DETERMINATION OF ELIGIBILITY.—

''(A) SCHIP AGENCY.—

''(i) IN GENERAL.—The determination of whether an individual is an eligible low-income individual for purposes of this section shall be made by the State agency with responsibility for determining the eligibility of individuals for assistance under the State children's health insurance program under title XXI of the Social Security Act.

''(ii) APPLICATION OF SCREEN AND ENROLL REQUIREMENTS.—

''(I) IN GENERAL.—The State agency referred to in clause (i) shall ensure that individuals applying for a certificate of eligibility are screened for potential eligibility under the medicaid and State children's health insurance programs and that individuals found through screening to be eligible for assistance under such a program are enrolled for assistance under the appropriate program. To the maximum extent possible pursuant to State options under title XIX of the Social Security Act, and notwithstanding any otherwise applicable provision of, or State plan provision under, such title, screening and enrollment activities described in the previous sentence shall use the procedures employed by the State children's health insurance program operated under title XXI of the Social Security Act, if such procedures differ from those ordinarily employed by the State program operated under title XIX of such Act.

''(II) NO DELAY OF ISSUANCE OF CERTIFICATE.—The application of the screen and enroll requirements of clause (i) shall not delay the issuance of a certificate of eligibility to an individual for purposes of this section. The State agency referred to in clause (i) shall adopt procedures to ensure than an individual issued a certificate of eligibility under this paragraph who is subsequently determined to be eligible for the State medicaid program under title XIX of the Social Security Act or the State children's health insurance program under XXI of such Act shall be enrolled in the appropriate program without an interruption in the individual's health insurance coverage.

''(B) STANDARDS.—

''(i) IN GENERAL.—An individual is an eligible low-income individual for purposes of this section if—

''(I) on the basis of the individual's tax return for the preceding taxable year, the individual meets the requirements of paragraph (1)(B), and the individual otherwise satisfies the requirements of paragraph (1), or

''(II) the individual is determined to satisfy the requirements of paragraph (1) after the application of the same eligibility methodologies as would apply for purposes of determining the eligibility of an individual for assistance under the State children's health insurance program under title XXI of the Social Security Act.

''(ii) APPLICATION OF SCHIP INCOME DETERMINATION METHODOLOGIES.—For purposes of clause (i)(II), determinations of income levels shall be made using the methodologies described in that clause, to the extent such methodologies for ascertaining household income differ from any otherwise applicable method for determining adjusted gross income or the definition of adjusted gross income.

''(C) CERTIFICATE OF ELIGIBILITY.—

''(i) IN GENERAL.—An individual who is determined to be an eligible low-income individual shall be issued a certificate of eligibility by the State agency referred to in subparagraph (A).

''(ii) CERTIFICATE AMOUNT.—Such certificate shall indicate the applicable percentage of the amount paid for coverage under qualified health insurance that the individual is eligible for under this section (including any supplemental assistance which the individual may be eligible for under subsection (b)(2), unless the individual elects to not receive such supplemental assistance).

''(iii) 12-MONTH PERIOD OF ISSUE.—The certificate of eligibility shall apply for a 12-month period from the date of issue, notwithstanding any changes in household circumstances following the individual's application for a credit under this section or supplemental assistance.

''(D) SUPPLEMENTAL ASSISTANCE.—The State agency described in subparagraph (A) shall determine an individual's eligibility for supplemental assistance under subsection (b)(2) based on the methodologies referred to in subparagraph (B)(ii).

''(f) QUALIFYING FAMILY MEMBER.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualifying family member' means—

''(A) the taxpayer's spouse, and

''(B) any dependent of the taxpayer with respect to whom the taxpayer is entitled to a deduction under section 151(c).

Such term does not include any individual who is not an eligible low-income individual under subsection (e)(1).

''(2) SPECIAL DEPENDENCY TEST IN CASE OF DIVORCED PARENTS, ETC.—If paragraph (2) or (4) of section 152(e) applies to any child with respect to any calendar year, in the case of any taxable year beginning in such calendar year, such child shall be treated as described in paragraph (1)(B) with respect to the custodial parent (within the meaning of section 152(e)(1)) and not with respect to the noncustodial parent.

''(g) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance' means any of the following:

''(A) Coverage under an insurance plan participating in a purchasing pool established pursuant to section 203 of the Health Coverage, Affordability, Responsibility, and Equity Act of 2003.

''(B) Coverage under individual health insurance pursuant to section 212 of such Act.

''(C) Coverage, pursuant to section 213 of such Act, under the medicaid program or the State children's health insurance program if 1 or more family members qualifies for coverage under such program.

''(D) Coverage, pursuant to section 214 of such Act, under an employer-sponsored insurance plan, including—

''(i) coverage under a COBRA continuation provision (as defined in section 9832(d)(1)),

''(ii) State-based continuation coverage provided under a State law that requires such coverage,

''(iii) coverage voluntarily offered by a former employer of the individual or family member; or

''(iv) coverage under a group health plan that is available through the employment of the individual or a family member.

''(2) EXCEPTION.—The term 'qualified health insurance' shall not include—

''(A) a flexible spending or similar arrangement, and

''(B) any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(3) DEFINITIONS.—For purposes of this subsection—

''(A) EMPLOYER-SPONSORED INSURANCE.—

''(i) IN GENERAL.—The term 'employer-sponsored insurance' means any insurance which covers medical care under any health plan maintained by any employer (or former employer) of the taxpayer or the taxpayer's spouse.

''(ii) TREATMENT OF CAFETERIA PLANS.—For purposes of clause (i), the cost of coverage shall be treated as paid or incurred by an employer to the extent the coverage is in lieu of a right to receive cash or other qualified benefits under a cafeteria plan (as defined in section 125(d)).

''(B) INDIVIDUAL HEALTH INSURANCE.—The term 'individual health insurance' means any insurance which constitutes medical care offered to individuals other than in connection with a group health plan and does not include Federal- or State-based health insurance coverage.

''(h) OTHER SPECIFIED COVERAGE.—For purposes of this section, an individual has other specified coverage for any month if, as of the first day of such month—

''(1) COVERAGE UNDER MEDICARE.—Such individual is entitled to benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title.

''(2) CERTAIN OTHER COVERAGE.—Such individual—

''(A) is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, or

''(B) is entitled to receive benefits under chapter 55 of title 10, United States Code.

''(i) FEDERAL POVERTY LEVEL; POVERTY LEVEL; POVERTY.—For purposes of this section, the terms 'Federal poverty level' , 'poverty level', and 'poverty' mean the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(j) SPECIAL RULES.—

''(1) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7528 for months beginning in such taxable year.

''(2) COORDINATION WITH OTHER DEDUCTIONS.—Amounts taken into account under subsection (a) shall not be taken into account in determining any deduction allowed under section 162(l) or 213.

''(3) MSA DISTRIBUTIONS.—Amounts distributed from an Archer MSA (as defined in section 220(d)) shall not be taken into account under subsection (a).

''(4) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(5) BOTH SPOUSES ELIGIBLE LOW-INCOME INDIVIDUALS.—The spouse of the taxpayer shall not be treated as a qualifying family member for purposes of subsection (a), if—

''(A) the taxpayer is married at the close of the taxable year,

''(B) the taxpayer and the taxpayer's spouse are both eligible low-income individuals during the taxable year, and

''(C) the taxpayer files a separate return for the taxable year.

''(6) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this section.

''(7) INSURANCE WHICH COVERS OTHER INDIVIDUALS.—For purposes of this section, rules similar to the rules of section 213(d)(6) shall apply with respect to any contract for qualified health insurance under which amounts are payable for coverage of an individual other than the taxpayer and qualifying family members.

''(8) TREATMENT OF PAYMENTS.—For purposes of this section:

''(A) PAYMENTS BY SECRETARY.—Any payment made by the Secretary on behalf of any individual under section 7528 (relating to advance payment of credit for health insurance costs of eligible low-income individuals) shall be treated as having been made by the taxpayer (or on behalf of the taxpayer) on the first day of the month for which such payment was made.

''(B) PAYMENTS BY TAXPAYER.—Any payment made by the taxpayer (or on behalf of the taxpayer) for eligible coverage months shall be treated as having been so made on the first day of the month for which such payment was made.

''(9) REGULATIONS.—

''(A) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services, shall administer the credit allowed under this section and shall prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section, section 6050U, and section 7528.

''(B) ELIGIBILITY DETERMINATIONS.—Such regulations shall include such standards as the Secretary of Health and Human Services may specify with respect to the requirements for eligibility determinations under subsection (e)(2).

''(C) MEASURES TO COMBAT FRAUD AND ABUSE.—Such regulations shall include appropriate procedures to deter, detect, and penalize fraudulent efforts to obtain a credit under this section by individuals, providers of qualified health insurance, and others.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period '', or from section 36 of such Code''.

(2) The table of sections for subpart C of part IV of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the last item and inserting the following new items:

''Sec. 36. Health insurance costs of eligible low-income individuals.

''Sec. 37. Overpayments of tax.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2005.

(d) REIMBURSEMENT FOR ADMINISTRATIVE COSTS INCURRED IN DETERMINING ELIGIBILITY FOR CREDIT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall reimburse States for the reasonable administrative costs incurred in making eligibility determinations in accordance with section 36(e) of the Internal Revenue Code of 1986 (as added by subsection (a)). Such reimbursement shall not apply to State costs required under the medicaid or State children's health insurance programs.

(2) APPLICATION.—A State desiring reimbursement under this subsection shall submit an application to the Secretary of Health and Human Services in such manner, at such time, and containing such information as the Secretary may require.

(3) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated such sums as may be necessary to carry out this subsection.

SEC. 112. ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

''SEC. 7528. ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.

''(a) GENERAL RULE.—Not later than August 1, 2005, the Secretary shall establish a program for making payments on behalf of certified individuals to providers of qualified health insurance (as defined in section 36(g)) for such individuals.

''(b) LIMITATION ON ADVANCE PAYMENTS DURING ANY TAXABLE YEAR.—The Secretary may make payments under subsection (a) only to the extent that the total amount of such payments made on behalf of any individual during the taxable year is not reasonably expected to exceed the applicable percentage (as defined in section 36(b)) of the amount paid by the taxpayer (or on behalf of the taxpayer) for coverage of the taxpayer and qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

''(c) CERTIFIED INDIVIDUAL.—For purposes of this section, the term 'certified individual' means any individual for whom a health coverage eligibility certificate is in effect.

''(d) HEALTH COVERAGE ELIGIBILITY CERTIFICATE.—For purposes of this section, the term 'health coverage eligibility certificate' means any written statement that an individual is an eligible low-income individual (as defined in section 36(e)) if such statement provides such information as the Secretary may require for purposes of this section and is issued by the State agency responsible for administering the State children's health insurance program under title XXI of the Social Security Act.''.

(b) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end the following new paragraph:

''(19) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.—The Secretary may disclose to providers of health insurance for any certified individual (as defined in section 7528(c)) return information with respect to such certified individual only to the extent necessary to carry out the program established by section 7528 (relating to advance payment of credit for health insurance costs of eligible low-income individuals).''.

(2) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Subsection (p) of such section is amended—

(A) in paragraph (3)(A) by striking ''or (18)'' and inserting ''(18), or (19)'', and

(B) in paragraph (4), as amended by section 202(b)(2)(B) of the Trade Act of 2002 (Public Law 107–210; 116 Stat. 961), by striking ''or (17)'' after ''any other person described in subsection (l)(16)'' each place it appears and inserting ''(18), or (19)''.

(3) UNAUTHORIZED INSPECTION OF RETURNS OR RETURN INFORMATION.—Section 7213A(a)(1)(B) of such Code is amended by striking ''section 6103(n)'' and inserting ''subsection (l)(18) or (19) or (n) of section 6103''.

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050T the following new section:

''SEC. 6050U. RETURNS RELATING TO CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.

''(a) REQUIREMENT OF REPORTING.—Every person who is entitled to receive payments for any month of any calendar year under section 7528 (relating to advance payment of credit for health insurance costs of eligible low-income individuals) with respect to any certified individual (as defined in section 7528(c)) shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual.

''(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

''(A) the name, address, and TIN of each individual referred to in subsection (a),

''(B) the number of months for which amounts were entitled to be received with respect to such individual under section 7528 (relating to advance payment of credit for health insurance costs of eligible low-income individuals),

''(C) the amount entitled to be received for each such month, and

''(D) such other information as the Secretary may prescribe.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xii) through (xviii) as clauses (xiii) through (xix), respectively, and by inserting after clause (xi) the following new clause:

''(xii) section 6050U (relating to returns relating to credit for health insurance costs of eligible low-income individuals),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (AA), by striking the period at the end of subparagraph (BB) and inserting '', or'', and by adding after subparagraph (BB) the following new subparagraph:

''(CC) section 6050U (relating to returns relating to credit for health insurance costs of eligible low-income individuals).''.

(d) CLERICAL AMENDMENTS.—

(1) ADVANCE PAYMENT.—The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 7528. Advance payment of credit for health insurance costs of eligible low-income individuals.''.

(2) INFORMATION REPORTING.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050T the following new item:

''Sec. 6050U. Returns relating to credit for health insurance costs of eligible low-income individuals.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2006.

TITLE II—IMPROVING ACCESS TO HEALTH PLANS

SEC. 201. DEFINITIONS.

In this title:

(1) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means an individual with respect to whom a tax credit is allowed under section 36 of the Internal Revenue Code of 1986 (as added by section 111).

(2) PARTICIPATING INSURER.—The term ''participating insurer'' means an entity with a contract under section 205(a).

(3) PRIVATE GROUP HEALTH INSURANCE PLAN.—The term ''private group health insurance plan'' means a plan offered by a participating insurer that provides health benefits coverage to eligible individuals and that meets the requirements of this title.

(4) PURCHASING POOL OPERATOR.—The term ''purchasing pool operator'' means the entity designated by the State under section 204.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(6) SMALL EMPLOYER.—The term ''small employer'' means an employer with not less than 2 and not more than 100 employees.

SEC. 202. ESTABLISHMENT OF HEALTH INSURANCE PURCHASING POOLS.

There is established a program under which the Secretary shall ensure that each eligible individual has the opportunity to enroll, through a purchasing pool operator, in a private group health insurance plan offered by a participating insurer under this title.

SEC. 203. PURCHASING POOLS.

(a) ESTABLISHMENT OF PURCHASING POOLS.—Each State participating in the program under this title shall establish a purchasing pool that is available to each eligible individual who resides in the State.

(b) TYPES OF PURCHASING POOLS.—

(1) IN GENERAL.—A purchasing pool established under subsection (a) shall be 1 of the following:

(A) A statewide purchasing pool operated by the State.

(B) A statewide purchasing pool operated on behalf of the State by the Director of the Office of Personnel Management, or the designee of such Director.

(2) OPM OPERATED POOL.—In the case of a statewide purchasing pool described in paragraph (1)(B), the Director of the Office of Personnel Management or the Director's designee, may limit participating insurers in such pool to those described in section 205(e), except that the Director or such designee shall ensure that additional private group health insurance plans participate in such a pool to the extent necessary to meet the requirements of section 204(c)(9).

(c) STATE ELECTION PROCESS.—

(1) IN GENERAL.—Each State participating in the program under this title shall notify the Secretary, not later than January 4, 2005, of the type of purchasing pool that applies to residents of the State.

(2) DEFAULT CHOICE.—If a State participating in the program under this title fails to notify the Secretary of the type of purchasing pool elected by the State by the date described in paragraph (1), the State shall be deemed to have elected the type of purchasing pool described in subsection (b)(1)(B).

(3) CHANGE OF ELECTION.—The Secretary shall establish procedures under which a State participating in the program under this title may change the election of the type of purchasing pool applicable to residents of the State.

SEC. 204. PURCHASING POOL OPERATORS.

(a) DESIGNATION.—Each State shall designate a purchasing pool operator that shall be responsible for operating the purchasing pool established under section 203(a). A purchasing pool operator may be (or, to have 1 or more of its functions performed, may contract with) a private entity that has entered into a contract with the State if such entity meets requirements established by the Secretary for purposes of the program under this title.

(b) OPERATION SIMILAR TO FEHBP.—Each purchasing pool operator shall operate the purchasing pool established under section 203(a) in a manner that is similar to the manner in which the Director of the Office of Personnel Management operates the Federal employees' health benefits program under chapter 89 of title 5, United States Code, including (but not limited to) the performance of the specific functions described in subsection (c).

(c) SPECIFIC FUNCTIONS DESCRIBED.—The specific functions described in this subsection include the following:

(1) Each purchasing pool operator shall offer one-stop shopping for eligible individuals to enroll for health benefits coverage

under private, group health insurance plans offered by participating insurers.

(2) Each purchasing pool operator shall limit participating insurers to those that meet the conditions for participation described in this title.

(3) Each purchasing pool operator shall negotiate (or, in the case of a purchasing pool described in section 203(b)(1)(B), shall negotiate or otherwise determine) bids and terms of coverage with insurers.

(4) Each purchasing pool operator shall provide eligible individuals with comparative information on private group health insurance plans offered by participating insurers.

(5) Each purchasing pool operator shall assist eligible individuals in enrolling with a private group health insurance plan offered by a participating insurer.

(6) Each purchasing pool operator shall collect private group health insurance plan premium payments for participating insurers and process such premium payments.

(7) Each purchasing pool operator shall reconcile from year to year aggregate premium payments and claims costs of private group health insurance plans consistent with practices under the Federal employees' health benefits program under chapter 89 of title 5, United States Code.

(8) Each purchasing pool operator shall offer customer service to eligible individuals enrolled for health benefits coverage under a private group health insurance plan offered by a participating insurer.

(9) Each purchasing pool operator shall ensure that each eligible individual has the option of enrolling in either of at least 2 benchmark or benchmark-equivalent plans with—

(A) a premium at or below a cap established by the pool operator for purposes of this title; and

(B) coverage of essential services included in the report required under section 301(e)(2), with cost-sharing consistent with such report.

(10) Each purchasing pool operator shall establish a premium cap for purposes of determining the credit limitation under section 36(c) of the Internal Revenue Code of 1986, as added by section 111(a). The cap required under this paragraph may not be less than the premium charged to Federal employees by the most highly-enrolled health plan under the Federal employees' health benefits program under chapter 89 of title 5, United States Code. If the most highly-enrolled plan in that program differs for Federal enrollees in the State and all Federal enrollees nationally in such plan, the minimum permitted premium cap shall be the lower of such premiums.

SEC. 205. CONTRACTS WITH PARTICIPATING INSURERS.

(a) IN GENERAL.—Each purchasing pool operator shall negotiate and enter into contracts for the provision of health benefits coverage under the program under this title with entities that meet the conditions of participation described in subsection (b) and other applicable requirements of this Act.

(b) CONSUMER INFORMATION.—In carrying out its duty under section 204(c)(4) to inform eligible individuals about private group health plans, the purchasing pool operator shall provide information that meets the requirements of section 212(b)(2).

(c) STATE LICENSURE.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan shall not be a participating insurer unless the plan has a State license to provide State residents with the private group coverage health insurance plans that it offers through the pool.

(2) EXCEPTION.—A pool operator may enter into a contract under subsection (a) to cover pool participants through a health plan without a State license described in paragraph (1) if such plan is offered to Federal employees nationwide and, with respect to such employees, is exempt from State health insurance regulation. Nothing in this paragraph shall be construed to permit coverage of pool participants through such a plan except with groups, contracts, and premium rates that are entirely distinct from those used for individuals covered under the Federal employee's health benefits program under chapter 89 of title 5, United States Code.

(d) ADDITIONAL STOP-LOSS COVERAGE AND REINSURANCE.—Purchasing pool operators are authorized to encourage participation in the program under this title, improve covered benefits, reduce out-of-pocket cost-sharing, limit premiums, or achieve other objectives of this Act by—

(1) funding stop-loss coverage above levels otherwise offered in the purchasing pool; or

(2) providing or subsidizing reinsurance in addition to that provided under section 211.

(e) PARTICIPATION OF FEHBP PLANS.—

(1) IN GENERAL.—Each entity with a contract under section 8902 of title 5, United States Code, shall be a participating insurer unless such entity notifies the Secretary in writing of its intention not to participate in the program under this title prior to such time as is designated by the Secretary so as to allow such decisions to be taken into account with respect to eligible individuals' choice of a private group health insurance plan under such program. Such participation in the program under this title shall include at least the covered benefits and provider networks available through such an entity and shall not involve greater out-of-pocket cost-sharing than the plan offered by such entity pursuant to its contract under section 8902 of title 5, United States Code.

(2) NO EFFECT ON FEHBP COVERAGE.—The Director of Office of Personnel Management shall take such steps as are necessary to ensure that each individual enrolled for health benefits coverage under the program under chapter 89 of title 5, United States Code, is not adversely affected by eligible individuals or others enrolled for coverage under the program under this title. Such steps shall include (but need not be limited to) the establishment of separate risk pools, separate contracts with participating insurers, and separately negotiated premiums.

SEC. 206. OPTIONS FOR HEALTH BENEFITS COVERAGE.

(a) SCOPE OF HEALTH BENEFITS COVERAGE.—The health benefits coverage provided to an eligible individual under a private group health insurance plan offered by a participating insurer shall consist of any of the following:

(1) BENCHMARK COVERAGE.—Health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

(2) BENCHMARK-EQUIVALENT COVERAGE.—Health benefits coverage that meets the following requirements:

(A) INCLUSION OF ESSENTIAL SERVICES.—The coverage includes each of the essential services identified by the National Advisory Commission on Expanded Access to Health Care and adopted by Congress under title III.

(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is equal to or greater than the actuarial value of one of the benchmark benefit packages.

(3) ALTERNATIVE COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, offers health benefits coverage equivalent to or greater than a plan described in and offered under section 8903(1) of title 5, United States Code.

(b) BENCHMARK BENEFIT PACKAGES.—The benchmark benefit packages are as follows:

(1) FEHBP-EQUIVALENT HEALTH BENEFITS COVERAGE.—The plan described in and offered under chapter 89 of title 5, United States Code with the highest number of enrollees under such section for the year preceding the year in which the private group health insurance plan is proposed to be offered.

(2) PUBLIC PROGRAM-EQUIVALENT HEALTH BENEFITS COVERAGE.—Coverage provided under the State plan approved under the medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act (42 U.S.C. 1396 et seq., 1397aa et seq.) (without regard to coverage provided under a waiver of the requirements of either such program).

(3) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act (42 U.S.C. 33gg–91(b)(3))), and

(B) has the largest insured commercial, nonmedicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State.

(4) STATE EMPLOYEE COVERAGE.—The health insurance plan that is offered to State employees and has the largest enrollment of covered lives of any such plan.

(5) APPLICATION OF BENCHMARK STANDARDS.—A private group health plan offers benchmark benefits if, with respect to a benchmark plan described in paragraph (1), (2), (3), or (4), the private group health plan covers all items and services offered by the benchmark plan, with out-of-pocket cost-sharing for such items and services that is not greater than under the benchmark plan. Nothing in this title shall be construed to forbid a private group health plan from offering additional items and services not covered by such a benchmark plan or reducing out-of-pocket cost-sharing below levels applicable under such plan.

SEC. 207. ENROLLMENT PROCESS FOR ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—The Secretary shall establish a process through which an eligible individual—

(1) may make an annual election to enroll in any private group health insurance plan offered by a participating insurer that has been awarded a contract under section 205(a) and serves the geographic area in which the individual resides, provided that such insurer's geographic area of service and guaranteed issuance under this section is conterminous with, or includes all of, a geographic area served pursuant to an entity's contact under section 8902 of title 5, United States Code; and

(2) may make an annual election to change the election under this clause.

(b) RULES.—In establishing the process under subsection (a), the Secretary shall use rules similar to the rules for enrollment, disenrollment, and termination of enrollment under the Federal employees health benefits program under chapter 89 of title 5, United States Code, including the application of the guaranteed issuance provision described in subsection (c).

(c) GUARANTEED ISSUANCE.—An eligible individual who is eligible to enroll for health benefits coverage under a private group health insurance plan that has been awarded a contract under section 205(a) at a time during which elections are accepted under this title with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(1))) or any other factor.

SEC. 208. PLAN PREMIUMS.

(a) IN GENERAL.—Each purchasing pool operator shall negotiate (or, in the case of a purchasing pool operated pursuant to section 203(b)(1)(B), shall otherwise determine) a premium for each private group health insurance plan offered by a participating insurer.

(b) PERMITTED PROFIT MARGINS.—

(1) IN GENERAL.—Each premium negotiated under subsection (a) may not permit a profit margin that exceeds the applicable percentage (as defined in paragraph (2)).

(2) APPLICABLE PERCENTAGE DEFINED.—In this subsection, the term ''applicable percentage'' means—

(A) for the first 3 years that a purchasing pool is operated, 2 percent;

(B) for any subsequent year, the percentage determined by the purchasing pool operator, which may not be—

(i) less than the profit margin permitted under the Federal employees health benefits program under chapter 89 of title 5, United States Code; or

(ii) more than a multiple, established by the Secretary for purposes of this subsection, of profit margins permitted under such program.

SEC. 209. ENROLLEE PREMIUM SHARE.

(a) IN GENERAL.—A participating insurer offering a private group health insurance plan that has been awarded a contract under section 205(a) in which the eligible individual is enrolled may not deny, limit, or condition the coverage (including out-of-pocket cost-sharing) or provision of health benefits coverage or vary or increase the enrollee premium share under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(1)) or any other factor.

(b) RISK-ADJUSTED PLAN PAYMENTS AND PREMIUMS CHARGED TO ENROLLEES.—

(1) IN GENERAL.—For each private group health insurance plan operated by a participating insurer, the pool operator shall adjust premium payments to compensate for the difference in health risk factors between plan enrollees and State residents as a whole (including residents who are not eligible individuals). Such adjustments shall employ risk-adjustment mechanisms promulgated by the Secretary.

(2) ADDITIONAL ADJUSTMENTS.—The pool operator shall also provide additional adjustments to premium payments that compensate participating insurers for the cost of keeping out-of-pocket cost-sharing amounts consistent with section 204(c)(9)(B).

(3) ENROLLEE PREMIUM COSTS.—The adjustments described in this subsection shall not affect enrollee premium shares, which shall be based on the premium that would be charged for enrollees with health risk factors for State residents as a whole (as described in paragraph (1)), without taking into account cost-sharing adjustments under section 204(c)(9)(B).

(c) AMOUNT OF PREMIUM.—The amount of the enrollee premium share shall be equal to premium amounts (if any) above the applicable cap set pursuant to section 204(c)(10), plus 100 percent of the remainder minus the applicable percentage (as defined in section 36(b) of the Internal Revenue Code of 1986, as added by section 111).

SEC. 210. PAYMENTS TO PURCHASING POOL OPERATORS AND PAYMENTS TO PARTICIPATING INSURERS.

The Secretary shall establish procedures for making payments to each purchasing pool operator as follows:

(1) RISK-ADJUSTMENT PAYMENT.—The Secretary shall pay each purchasing pool operator for the net costs of risk-adjusted payments to plans under section 209(b), to the extent the sum of upward adjustments exceeds the sum of downward adjustments for the pool operator.

(2) STOP-LOSS AND REINSURANCE PAYMENTS.—

(A) IN GENERAL.—The Secretary shall pay each purchasing pool operator for the applicable percentage (as defined in subparagraph (B)) of—

(i) the costs of any stop-loss coverage funded by the purchasing pool operator under section 205(d)(1); and

(ii) any reinsurance provided in accordance with section 205(d)(2).

(B) APPLICABLE PERCENTAGE DEFINED.—In this paragraph, the term ''applicable percentage'' means—

(i) for the first 3 years that a purchasing pool is operated, 100 percent;

(ii) for the next 2 years that such purchasing pool is operated, 50 percent; and

(iii) for any subsequent year, 0 percent.

(3) PAYMENTS NECESSARY TO KEEP COST-SHARING WITHIN APPLICABLE LIMITS.—The Secretary shall make payments to purchasing pool operators to reimburse purchasing pool operators for the amount paid by such operators to participating insurers necessary to keep out-of-pocket cost-sharing for individuals with limited ability to pay within applicable limits.

(4) PAYMENT FOR ADMINISTRATIVE COSTS.—The Secretary shall make payments to each purchasing pool operator for necessary pool administrative expenses.

(5) PAYMENTS TO OPM.—In the case of a purchasing pool described in section 203(b)(1)(B), payments under this section shall be made to the Director of the Office of Personnel Management.

SEC. 211. STATE-BASED REINSURANCE PROGRAMS.

(a) ESTABLISHMENT.—The Secretary shall establish standards for State-based reinsurance programs for eligible individuals to guard against adverse selection and to improve the functioning of the individual health insurance market.

(b) GRANTS FOR STATEWIDE REINSURANCE PROGRAMS.—

(1) IN GENERAL.—The Secretary may award grants to States for the reasonable costs incurred in providing reinsurance under this section, consistent with standards developed by the Secretary, for coverage offered in the individual health insurance market and through State-based purchasing pools described in section 203.

(2) LIMITATION.—Such grants may not pay for reinsurance extending beyond individuals in the top 3 percent of the national health care spending distribution, as determined by the Secretary.

(3) APPLICATION.—A State desiring a grant under this section shall submit an application to the Secretary in such manner, at such time, and containing such information as the Secretary may require.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary for making grants under this section.

SEC. 212. COVERAGE UNDER INDIVIDUAL HEALTH INSURANCE.

(a) IN GENERAL.—Eligible individuals may use credits allowed under the Internal Revenue Code of 1986 (including supplemental assistance provided under such Code) for the purchase of health insurance coverage to enroll in State-licensed individual health insurance meeting the conditions of participation described in subsection (b).

(b) CONDITIONS OF PARTICIPATION.—The Secretary shall promulgate regulations that establish the terms and conditions under which an entity may participate in the program under this section and that include the following:

(1) PLAN MARKETING.—Conditions of participation for plans in the individual market (as developed by the Secretary) that—

(A) ensure that consumers receive the consumer information described in paragraph (2) before selecting a plan; and

(B) detect, deter, and penalize marketing fraud by entities offering or purporting to offer individual insurance.

(2) CONSUMER INFORMATION.—Requirements for each entity offering individual insurance to provide eligible individuals with information in a uniform and easily comprehensible manner that allows for informed comparisons by eligible individuals and that includes information regarding the health benefits coverage, costs, provider networks, quality, the amount and proportion of health insurance premium payments that go directly to patient care, and the plan's coverage rules (including amount, duration, and scope limits) and out-of-pocket cost-sharing (both inside and outside plan networks) for each essential service recommended by the National Advisory Commission on Expanded Access to Health Care and adopted by Congress under title III (which shall be prominently identified as an essential service, including by reference to the Commission recommendation denoting the service as essential). To the maximum extent feasible, such requirements shall specify that the content and presentation of the information shall be provided in the same manner as similar information is presented to enrollees in the Federal employees health benefits program under chapter 89 of title 5, United States Code.

(3) OTHER CONDITIONS, INCLUDING THE ELIMINATION OF BARRIERS TO AFFORDABLE COVERAGE.—

(A) IN GENERAL.—Requirements for each entity offering individual insurance to abide by conditions of participation that the Secretary believes are reasonable and appropriate measures to address barriers to affordable health insurance coverage.

(B) SPECIFIC CONDITIONS.—The requirements developed by the Secretary under subparagraph (A) shall include (but need not be limited to)—

(i) guaranteed renewability, without premium increases based on changed individual risk; and

(ii) limits on risk rating.

(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to authorize the Secretary to impose any requirements on individual insurance, except with respect to eligible individuals purchasing individual insurance using advance payment of a tax credit provided under section 36 of the Internal Revenue Code of 1986.

SEC. 213. USE OF PREMIUM SUBSIDIES TO UNIFY FAMILY COVERAGE WITH MEMBERS ENROLLED IN MEDICAID AND SCHIP.

Notwithstanding any other provision of law, the Secretary shall establish procedures under which, in the case of a family with 1 or more members enrolled in with a managed care entity under the State medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act (42 U.S.C. 1396 et seq., 1397aa et seq.) and 1 or more members who are an eligible individual under this title, the family shall have the option to enroll all family members with the managed care entity under either or both such State programs. The procedures established by the Secretary shall provide that premiums charged to eligible individuals for enrollment with such an entity shall be based on the capitated payments established for adults or children, excluding adults and children who are known to be pregnant, blind, disabled, or (in the case of adults) elderly, under the applicable State program

(except that, in the case of an eligible individual known to be pregnant, premiums shall reflect capitated payments established under such State program for individuals known to be pregnant) plus reasonable administrative costs.

SEC. 214. COVERAGE THROUGH EMPLOYER-SPONSORED HEALTH INSURANCE.

(a) IN GENERAL.—Eligible individuals may use credits allowed under the Internal Revenue Code of 1986 and supplemental assistance to enroll in coverage offered by eligible employers.

(b) ELIGIBLE EMPLOYERS.—For purposes of this section, the term ''eligible employers'' includes the following:

(1) The current employer of the eligible individual or a member of such individuals family.

(2) A former employer required to offer coverage of the eligible individual under a COBRA continuation provision (as defined in section 9832(d)(1) of the Internal Revenue Code) or a State law requiring continuation coverage; and

(3) A former employer voluntarily offering coverage of the eligible individual.

(c) APPLICATION OF DISREGARD OF PREEXISTING CONDITIONS EXCLUSIONS.—Notwithstanding any other provision of law, in the case of an individual who experiences a qualifying event (as defined in section 603 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163) and who, not later than 6 months after such event, is determined to be an eligible individual under this title, the same rules with respect to preexisting conditions as apply to a nonelecting TAA-eligible individual under section 605(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(b)) shall apply with respect to such individual, regardless of which type of qualified coverage the individual purchases.

(d) EXTENSION OF COBRA ELECTION PERIOD.—Notwithstanding any other provision of law, in the case of an individual who experiences a qualifying event (as defined in section 603 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163) and who, not later than 6 months after such event, is determined to be an eligible individual under this title, the same rules with respect to the temporary extension of a COBRA election period as apply to a nonelecting TAA-eligible individual under section 605(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(b)) shall apply with respect to such individual.

(e) CURRENT EMPLOYER COVERAGE.—If an eligible individual uses the credits allowed under the Internal Revenue Code of 1986 and supplemental assistance to purchase coverage from an employer described in subsection (b), such credits and assistance shall apply as a percentage, not of the total premium amount for the eligible individual, but of the employee's or former employee's share of premium payments.

SEC. 215. PARTICIPATION BY SMALL EMPLOYERS.

(a) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary shall establish procedures under which, during annual open enrollment periods, a small employer shall have the option of purchasing group coverage for employees and dependents of employees, including individuals who are not otherwise eligible individuals under this title, through a purchasing pool established under section 203(a).

(b) CONDITIONS OF PARTICIPATION.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the same requirements that apply with respect to participating insurers covering eligible low-income individuals under section 203 shall apply with respect to coverage offered by such insurers through a small employer.

(2) RISK ADJUSTMENT.—

(A) INCREASED PAYMENTS.—If employees of a small employer who are not otherwise eligible individuals under this title enroll in a private group health insurance plan under this title and have a collective risk level that exceeds the statewide average (as determined pursuant to risk adjustment mechanisms developed by the Secretary consistent with section 209(b)(1)), the Secretary (through a pool operator) shall provide participating insurers with such small employer enrollment bonus payments as are necessary to compensate the insurers for such increased risk. The premium charged to enrollees under this section shall be the same premium that is the basis of premium charges to enrollees who are eligible low-income individuals.

(B) REDUCED PAYMENTS.—A pool operator shall reduce payments to any plan with a risk level that falls below the statewide average (as so determined).

(3) ADMINISTRATIVE GUIDELINES.—The Secretary shall develop guidelines for pool operators to use in serving small employers, which shall be modeled after existing, successful, longstanding small business purchasing cooperatives, and shall include administratively simple methods for small employers and licensed insurance brokers to participate in the program established under this title.

(c) INFORMATION CAMPAIGN.—

(1) IN GENERAL.—The pool operator for a State shall establish and conduct, directly or through 1 or more public or private entities (which may include licensed insurance brokers), a health insurance information program to inform small employers about health coverage for employees.

(2) REQUIREMENTS.—The program established under paragraph (1) shall educate small employers with respect to matters that include (but are not limited to) the following:

(A) The benefits of providing health insurance to employees, including tax benefits to both the employer and employees, increased productivity, and decreased employee turnover.

(B) The rights of small employers under Federal and State health insurance reform laws.

(C) Options for purchasing coverage, including (but not limited to) through the State's purchasing pool operated pursuant to section 203.

(d) GRANTS TO HELP STATE-BASED POOLS PROMOTE SMALL BUSINESS COVERAGE.—

(1) IN GENERAL.—The Secretary may award grants to a pool operator for the following:

(A) The net costs of risk-adjusted payments under paragraph (b)(2), to the extent the sum of upward adjustments exceeds the sum of downward adjustments for the pool operator.

(B) The reasonable cost of the information campaign under subsection (c).

(C) The pool operator's reasonable administrative costs to implement this section.

(2) LIMITATION.—This section shall not apply to a State's pool unless sufficient grant funds have been received under this subsection to implement this section on a fiscally sound basis and such receipt is certified by the pool operator.

(3) APPLICATION.—A pool operator desiring a grant under this section shall submit an application to the Secretary in such manner, at such time, and containing such information as the Secretary may require.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary for making grants under this section.

SEC. 216. REPORT.

Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report containing recommendations for such legislative and administrative changes as the Secretary determines are appropriate to permit affinity groups related for reasons other than a common employer to participate in purchasing pools established under section 203.

SEC. 217. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated, such sums as may be necessary to carry out this title for fiscal year 2006 and each fiscal year thereafter.

(b) RULE OF CONSTRUCTION.—Amounts appropriated in accordance with subsection (a) shall be in addition to other amounts appropriated directly under this title and nothing in subsection (a) shall be construed to relieve the Secretary of mandatory payment obligations required under this title.

TITLE III—NATIONAL ADVISORY COMMISSION ON EXPANDED ACCESS TO HEALTH CARE

SEC. 301. NATIONAL ADVISORY COMMISSION ON EXPANDED ACCESS TO HEALTH CARE.

(a) ESTABLISHMENT.—Not later than October 1, 2003, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), shall establish an entity to be known as the National Advisory Commission on Expanded Access to Health Care (referred to in this section as the ''Commission'').

(b) APPOINTMENT OF MEMBERS.—

(1) IN GENERAL.—Not later than 45 days after the date of enactment of this Act, the House and Senate Majority and Minority Leaders shall each appoint 4 members of the Commission and the Secretary shall appoint 1 member.

(2) CRITERIA.—Members of the Commission shall include representatives of the following:

(A) Consumers of health insurance.

(B) Health care professionals.

(C) State officials.

(D) Economists.

(E) Health care providers.

(F) Experts on health insurance.

(G) Experts on expanding health care to individuals who are uninsured.

(3) CHAIRPERSON.—At the first meeting of the Commission, the Commission shall select a Chairperson from among its members.

(c) MEETINGS.—

(1) IN GENERAL.—After the initial meeting of the Commission which shall be called by the Secretary, the Commission shall meet at the call of the Chairperson.

(2) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(3) SUPERMAJORITY VOTING REQUIREMENT.—To approve a report required under paragraph (2) or (3) of subsection (e), at least 60 percent of the membership of the Commission must vote in favor of such a report.

(d) DUTIES.—The Commission shall—

(1) assess the effectiveness of programs designed to expand health care coverage or make health care coverage affordable to the otherwise uninsured individuals through identifying the accomplishments and needed improvements of each program;

(2) make recommendations about benefits and cost-sharing to be included in health care coverage for various groups, taking into account—

(A) the special health care needs of children and individuals with disabilities;

(B) the different ability of various populations to pay out-of-pocket costs for services;

(C) incentives for efficiency and cost-control; and

(D) preventative care, disease management services, and other factors;

(3) recommend mechanisms to discourage individuals and employers from voluntarily opting out of health insurance coverage;

(4) recommend mechanisms to expand health care coverage to uninsured individuals with incomes above 200 percent of the official income poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;

(5) recommend automatic enrollment and retention procedures and other measures to increase health care coverage among those eligible for assistance;

(6) review the roles, responsibilities, and relationship between Federal and State agencies with respect to health care coverage and recommend improvements; and

(7) analyze the size, effectiveness, and efficiency of current tax and other subsidies for health care coverage and recommend improvements.

(e) REPORTS.—

(1) ANNUAL REPORT.—The Commission shall submit annual reports to the President and Congress addressing the matters identified in subsection (d).

(2) BIENNIAL REPORT.—

(A) IN GENERAL.—The Commission shall submit biennial reports to the President and Congress, which shall contain—

(i) recommendations concerning essential benefits and maximum out-of-pocket cost-sharing (for the general population and for individuals with limited ability to pay, which shall not exceed the out-of-pocket cost-sharing permitted under section 2103(e) of the Social Security Act (42 U.S.C. 1397cc(e))) for the coverage options described in title II; and

(ii) proposed legislative language to implement such recommendations.

(B) CONGRESSIONAL ACTION.—The legislative language proposed under subparagraph (A)(ii) shall proceed to immediate consideration on the floor of the House of Representatives and the Senate and shall be approved or rejected, without amendment, using procedures employed for recommendations of military base closing commissions.

(3) COMMISSION REPORT.—No later than January 15, 2007, the Commission shall submit a report to the President and Congress, which shall include—

(A) recommendations on policies to provide health care coverage to uninsured individuals with incomes above 200 percent of the official income poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;

(B) recommendations on changes to policies enacted under this Act; and

(C) proposed legislative language to implement such recommendations.

(f) ADMINISTRATION.—

(1) POWERS.—

(A) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(B) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission.

(C) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(D) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(2) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(3) STAFF.—

(A) IN GENERAL.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) STAFF COMPENSATION.—The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(C) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(D) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(g) TERMINATION.—Except with respect to activities in connection with the ongoing biennial report required under subsection (e)(2), the Commission shall terminate 90 days after the date on which the Commission submits the report required under subsection (e)(3).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for fiscal year 2004 and each fiscal year thereafter.

SEC. 302. CONGRESSIONAL ACTION.

(a) BILL INTRODUCTION.—

(1) IN GENERAL.—Any legislative language included in the report required under section 301(e)(3) may be introduced as a bill by request in the following manner:

(A) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader and the Minority Leader not later than 10 days after receipt of the legislative language.

(B) SENATE.—In the Senate, by the Majority Leader and the Minority Leader not later than 10 days after receipt of the legislative language.

(2) ALTERNATIVE BY ADMINISTRATION.—The President may submit legislative language based on the recommendations of the Commission and such legislative language may be introduced in the manner described in paragraph (1).

(b) COMMITTEE CONSIDERATION.—

(1) IN GENERAL.—Any legislative language submitted pursuant to paragraph (1) or (2) of subsection (a) (in this section referred to as ''implementing legislation'') shall be referred to the appropriate committees of the House of Representatives and the Senate.

(2) REPORTING.—

(A) COMMITTEE ACTION.—If, not later than 150 days after the date on which the implementing legislation is referred to a committee under paragraph (1), the committee has reported the implementing legislation or has reported an original bill whose subject is related to reforming the health care system, or to providing access to affordable health care coverage for Americans, the regular rules of the applicable House of Congress shall apply to such legislation.

(B) DISCHARGE FROM COMMITTEES.—

(i) SENATE.—

(I) IN GENERAL.—If the implementing legislation or an original bill described in subparagraph (A) has not been reported by a committee of the Senate within 180 days after the date on which such legislation was referred to committee under paragraph (1), it shall be in order for any Senator to move to discharge the committee from further consideration of such implementing legislation.

(II) SEQUENTIAL REFERRALS.—Should a sequential referral of the implementing legislation be made, the additional committee has 30 days for consideration of implementing legislation before the discharge motion described in subclause (I) would be in order.

(III) PROCEDURE.—The motion described in subclause (I) shall not be in order after the implementing legislation has been placed on the calendar. While the motion described in subclause (I) is pending, no other motions related to the motion described in subclause (I) shall be in order. Debate on a motion to discharge shall be limited to not more than 10 hours, equally divided and controlled by the Majority Leader and the Minority Leader, or their designees. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed or disagreed to.

(IV) EXCEPTION.—If implementing language is submitted on a date later than May 1 of the second session of a Congress, the committee shall have 90 days to consider the implementing legislation before a motion to discharge under this clause would be in order.

(ii) HOUSE OF REPRESENTATIVES.—If the implementing legislation or an original bill described in subparagraph (A) has not been reported out of a committee of the House of Representatives within 180 days after the date on which such legislation was referred to committee under paragraph (1), then on any day on which the call of the calendar for motions to discharge committees is in order, any member of the House of Representatives may move that the committee be discharged from consideration of the implementing legislation, and this motion shall be considered under the same terms and conditions, and if adopted the House of Representatives shall follow the procedure described in subsection (c)(1).

(c) FLOOR CONSIDERATION.—

(1) MOTION TO PROCEED.—If a motion to discharge made pursuant to subsection (b)(2)(B)(i) or (b)(2)(B)(ii) is adopted, then, not earlier than 5 legislative days after the date on which the motion to discharge is

adopted, a motion may be made to proceed to the bill.

(2) FAILURE OF MOTION.—If the motion to discharge made pursuant to subsection (b)(2)(B)(i) or (b)(2)(B)(ii) fails, such motion may be made not more than 2 additional times, but in no case more frequently than within 30 days of the previous motion. Debate on each of such motions shall be limited to 5 hours, equally divided.

(3) APPLICABLE RULES.—Once the Senate is debating the implementing legislation the regular rules of the Senate shall apply.

TITLE IV—STATE WAIVERS

SEC. 401. STATE WAIVERS.

(a) IN GENERAL.—Notwithstanding any other provision of law, a State may apply to the Secretary of Health and Human Services for waivers of such provisions of law as may be necessary for the State to implement policies that make comprehensive, affordable health coverage available for all State residents, including access to essential benefits with limits on cost-sharing, as provided in the most recent report under section 301(e)(2).

(b) REQUIREMENTS.—In order to ensure that waivers under this section benefit rather than harm health care consumers, a State shall not be eligible for a waiver under this section unless—

(1) the State reasonably expects to achieve a level of enrollment in coverage described in subsection (a) that is at least equal to the level of coverage (taking into account the number of insured individuals, covered benefits, and premium and out-of-pocket costs to the consumer for such coverage) that the State would have achieved if the State had fully implemented the coverage options available under titles I and II of this Act;

(2) no individual who would have qualified for assistance under the State medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act, as of either the date of the waiver request or the date of enactment of this Act, will be denied eligibility for such program, have a reduction in benefits under such program, have reduced access to geographically and linguistically appropriate care or essential community providers, or be subject to increased premiums or cost-sharing under the waiver program under this section; and

(3) the State agrees to comply with such standards or guidelines as the Secretary of Health and Human Services may require to ensure that the requirements of paragraphs (1) and (2) are satisfied.

(c) FEDERAL PAYMENTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall pay a State with a waiver approved under this section an amount each quarter equal to the sum of—

(A) the Federal payments the State and residents of the State (including, but not limited to, through the credit allowed under section 36 of the Internal Revenue Code of 1986 for health insurance costs) would have received if the State had exercised the coverage options under titles I and II of this Act with respect to residents of the State who have not attained age 65; and

(B) the amount of any grants authorized by this Act that the State would have received if the State had applied for such grants.

(2) ADDITIONAL PAYMENT FOR MEDICARE BENEFICIARIES UNDER AGE 65.—

(A) IN GENERAL.—In the case of a State that elects to enroll an individual described in subparagraph (B) in coverage described in subsection (a), the amount described in paragraph (1) with respect to a quarter shall be increased by the amount described in subparagraph (C).

(B) INDIVIDUAL DESCRIBED.—An individual is described in this subparagraph if the individual—

(i) has not attained age 65;

(ii) is eligible for coverage under title XVIII of the Social Security Act; and

(iii) voluntarily elects to enroll in coverage described in subsection (a).

(C) AMOUNT DESCRIBED.—The amount described in this subparagraph is the amount equal to the amount that the Federal Government would have incurred with respect to a quarter for providing coverage to an individual described in subparagraph (B) under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(d) IMPLEMENTATION DATE.—No State may submit a request for a waiver under this section before October 1, 2007.

By Mr. SARBANES (for himself, Mr. ALEXANDER, Mr. AKAKA, Mr. BAUCUS, Mr. CORZINE, Mr. DODD, Mr. GRAHAM of Florida, Mr. KENNEDY, Mr. LAUTENBERG, Mr. LEVIN, Mr. REID, Mr. SCHUMER, Ms. STABENOW, and Mr. WYDEN):

S. 1032. A bill to provide for alternative transportation in certain federally owned or managed areas that are open to the general public; to the Committee on Energy and Natural Resources.

Mr. SARBANES. Mr. President, I rise today to introduce legislation similar to measures I have introduced in previous Congresses that will help protect our Nation's natural resources and improve the visitor experience in our national parks and other public lands. The Transit in Parks Act, or ''TRIP,'' establishes a new Federal transit grant initiative to support the development of alternative transportation services for our national parks, wildlife refuges, Federal recreational areas, and other public lands. I am pleased to be joined by Senators AKAKA, ALEXANDER, BAUCUS, CORZINE, DODD, GRAHAM, KENNEDY, LAUTENBERG, LEVIN, REID, SCHUMER, STABENOW, and WYDEN, who are cosponsors of this legislation.

I want to underscore again today some of the principal arguments I have made in past years as to why this legislation is urgently needed. Memorial Day weekend, the opening of the summer travel season, is just weeks away. Millions of visitors will soon head to our national parks to enjoy the incredible natural heritage with which our Nation was endowed. But too many of them will spend hours looking for parking, or staring at the bumper of the car in front of them.

Clearly, the world has changed significantly since the national parks first opened in the second half of the nineteenth century, when visitors arrived by stagecoach along dirt roads. At that time, travel through parklands, such as Yosemite or Yellowstone, was long, difficult, and costly. Not many people could afford or endure such a trip. The introduction of the automobile gave every American greater mobility and freedom, which included the freedom to travel and see some of our Nation's great natural wonders. Early in this century, landscape architects from the National Park Service and highway engineers from the U.S. Bureau of Public Roads collaborated to produce many feats of road engineering that opened the national park lands to millions of Americans.

Yet greater mobility and easier access now threaten the very environments that the National Park Service is mandated to protect. The ongoing tension between preservation and access has always been a challenge for our national park system. Today, record numbers of visitors and cars have resulted in increasing damage to our parks. The Grand Canyon alone has almost five million visitors a year. As many as 6,000 vehicles arrive in a single summer day. They compete for 2,400 parking spaces. Between 32,000 and 35,000 tour buses go to the park each year. During the peak summer season, the entrance route becomes a giant parking lot.

In 1975, the total number of visitors to America's national parks was 190 million. By 2002, that number had risen to 277 million annual visitors—almost equal to one visit by every man, woman, and child in this country. This dramatic increase in visitation has created an overwhelming demand on these areas, resulting in severe traffic congestion, visitor restrictions, and in some instances vacationers being shut out of the parks altogether. The environmental damage at the Grand Canyon is visible at many other parks: Yosemite, which has more than four million visitors a year; Yellowstone, which has more than three million visitors a year and experiences such severe traffic congestion that access has to be restricted; Zion; Acadia; Bryce; and many others. We need to solve these problems now or risk permanent harm to our nation's natural, cultural, and historical heritage.

Visitor access to the parks is vital not only to the parks themselves, but to the economic health of their gateway communities. For example, visitors to Yosemite infuse $3 billion a year into the local economy of the surrounding area. At Yellowstone, tourists spend $725 million annually in adjacent communities. Wildlife-related tourism generates an estimated $60 billion a year nationwide. If the parks are forced to close their gates to visitors due to congestion, the economic vitality of the surrounding region would be jeopardized.

The challenge for park management has always been twofold: to conserve and protect the nation's natural, historical, and cultural resources, while at the same time ensuring visitor access and enjoyment of these sensitive environments. Until now, the principal transportation systems that the Federal Government has developed to provide access into our national parks are roads, primarily for private automobile access. The TRIP legislation recognizes that we need to do more than simply

build roads; we must invest in alternative transportation solutions before our national parks are damaged beyond repair.

In developing solutions to the parks' transportation needs, this legislation builds upon the 1997 Memorandum of Understanding between Secretary of Transportation Rodney Slater and Secretary of the Interior Bruce Babbitt, in which the two Departments agreed to work together to address transportation and resource management needs in and around national parks. The findings in the MOU are especially revealing: Congestion in and approaching many National Parks is causing lengthy traffic delays and backups that substantially detract from the visitor experience. Visitors find that many of the National Parks contain significant noise and air pollution, and traffic congestion similar to that found on the city streets they left behind.

In many National Park units, the capacity of parking facilities at interpretive or scenic areas is well below demand. As a result, visitors park along roadsides, damaging park resources and subjecting people to hazardous safety conditions as they walk near busy roads to access visitor use areas.

On occasion, National Park units must close their gates during high visitation periods and turn away the public because the existing infrastructure and transportation systems are at, or beyond, the capacity for which they were designed.

In addition, the TRIP legislation is designed to implement the recommendations from a comprehensive study of alternative transportation needs in public lands that I was able to include in the Transportation Equity Act for the 21st Century, TEA–21, as section 3039. The Federal Lands Alternative Transportation Systems Study confirmed what those of us who have visited our national parks already know: there is a significant and well-documented need for alternative transportation solutions in the national parks to prevent lasting damage to these incomparable natural treasures.

The study examined over two hundred sites, and identified needs for alternative transportation services at two-thirds of those sites. The study found that implementation of such services can help achieve a number of desirable outcomes: ''Relieve traffic congestion and parking shortages; enhance visitor mobility and accessibility; preserve sensitive natural, cultural, and historic resources; provide improved interpretation, education and visitor information services; reduce pollution; and improve economic development opportunities for gateway communities.''

In fact, the study concluded that ''the provision of transit in federally-managed lands can have national economic implications as well as significant economic benefits for local areas surrounding the sites.'' The study determined that funding transit needs would support thousands of jobs around the country, while also providing a direct benefit to the economy of gateway communities by ''expand[ing] the number of visits to the site and expand[ing] the amount of visitor spending in the surrounding communities.''

The study identified ''lack of a dedicated funding source for developing, implementing, and operating and maintaining transit systems'' as a key barrier to implementation of alternative transportation in and around federally-managed lands. The Transit in Parks Act will go far toward helping parks and their gateway communities overcome this barrier. This new Federal transit grant program will provide funding to the Federal land management agencies that manage the 388 various sites within the National Park System, the National Wildlife Refuges, Federal recreational areas, and other public lands, including National Forest System lands, and to their State and local partners.

The bill's objectives are to develop new and expanded transit services throughout the national parks and other public lands to conserve and protect fragile natural, cultural, and historical resources and wildlife habitats, to prevent or mitigate adverse impact on those resources and habitats, and to reduce pollution and congestion, while at the same time facilitating appropriate visitor access and improving the visitor experience. The program will provide capital funds for transit projects, including rail or clean fuel bus projects, joint development activities, pedestrian and bike paths, or park waterway access, within or adjacent to national parks and other public lands. The Secretary of Transportation may make funds available for operations as well. The bill authorizes $90 million for this new program for each of the fiscal years 2004 through 2009, consistent with the level of need identified in the study. It is anticipated that other resources—both public and private—will be available to augment these amounts.

The bill formalizes the cooperative arrangement in the 1997 MOU between the Secretary of Transportation and the Secretary of the Interior to exchange technical assistance and to develop procedures relating to the planning, selection and funding of transit projects in national park lands. The bill further provides funds for planning, research, and technical assistance that can supplement other financial resources available to the Federal land management agencies. The projects eligible for funding would be developed through the transportation planning process and prioritized for funding by the Secretary of the Interior in consultation and cooperation with the Secretary of Transportation. It is anticipated that the Secretary of the Interior would select projects that are diverse in location and size. While major national parks such as the Grand Canyon or Yellowstone are clearly appropriate candidates for significant transit projects under this section, there are numerous small urban and rural Federal park lands that can benefit enormously from small projects, such as bike paths or improved connections with an urban or regional public transit system. No single project will receive more than 12 percent of the total amount available in any given year. This ensures a diversity of projects selected for assistance.

In addition, I firmly believe that this program will create new opportunities for the Federal land management agencies to partner with local transit agencies in gateway communities adjacent to the parks, both through the TEA–21 planning process and in developing integrated transportation systems. This will spur new economic development within these communities, as they develop transportation centers for park visitors to connect to transit links into the national parks and other public lands.

The ongoing tension between preservation and access has always been a challenge for the National Park Service. Today, that challenge has new dimensions, with overcrowding, pollution, congestion, and resource degradation increasing at many of our national parks. This legislation—the Transit in Parks Act—will give our Federal land management agencies important new tools to improve both preservation and access. Just as we have found in metropolitan areas, transit is essential to moving large numbers of people in our national parks—quickly, efficiently, at low cost, and without adverse impact. At the same time, transit can enhance the economic development potential of our gateway communities.

As we begin a new millennium, I cannot think of a more worthy endeavor to help our environment and preserve our national parks, wildlife refuges, and Federal recreational areas than by encouraging alternative transportation in these areas. My bill is strongly supported by the National Parks Conservation Association, Environmental Defense, the American Public Transportation Association, Community Transportation Association, Amalgamated Transit Union, Surface Transportation Policy Project, Natural Resources Defense Council, Friends of the Earth, Rails-to-Trails Conservancy, America Bikes and others, and I ask unanimous consent that the bill, a section-by-section analysis, and letters of support be printed in the RECORD, along with the USA Today article, ''Save Parks: Park Cars.''

I believe that we have a clear choice before us: we can turn paradise into a parking lot—or we can invest in alternatives. I urge my colleagues to support the Transit in Parks Act to ensure that our Nation's natural treasures will be preserved for many generations to come.

By Mr. BINGAMAN (for himself, Mr. LUGAR, Mrs. LINCOLN, Mr.

CORZINE, Ms. LANDRIEU, Mr. BREAUX, Mr. KERRY, Ms. CANTWELL, Mrs. MURRAY, Mrs. CLINTON, and Mr. MILLER):

S. 1033. A bill to amend titles XIX and XXI of the Social Security Act to expand or add coverage of pregnant women under the medicaid and State children's health insurance program, and for other purposes; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, I rise today to introduce bipartisan legislation with Senators LUGAR, LINCOLN, CORZINE, LANDRIEU, BREAUX, KERRY, MURRAY, CANTWELL, CLINTON, and MILLER. This legislation, entitled the ''Start Healthy, Stay Healthy Act of 2003,'' would significantly reduce the number of uninsured pregnant women and newborns by expanding coverage to pregnant women through Medicaid and the Children's Health Insurance Program, or CHIP, and to newborns through the first full year of life.

Sunday is Mothers' Day. Every year, we honor our Nation's mothers and we should take the time to assess how we can do better by them, including their health and well-being.

According to a recent report by Save the Children entitled ''The State of the World's Mothers,'' the United States fares no better than 11th in the world. Why is this? According to the report, ''The United States earned its 11th place rank this year based on several factors: One of the key indicators used to calculate the well-being for mothers is lifetime risk of maternal mortality . . . Canada, Australia, and all the Western and Northern European countries in the study performed better than the United States in this indicator.''

The study adds, ''Similarly, the United States did not do as well as the top 10 countries with regard to infant mortality rates.''

In fact, the United States ranks 21st in maternal mortality and 28th in infant mortality, the worst among developed nations. We should and must do better by our Nation's mothers and infants.

Throughout our Nation's history, there has been long-standing policy linking programs for pregnant women and infants, including Medicaid, WIC, and the Maternal and Child Health Block Grant. CHIP, unfortunately, fails to provide coverage to pregnant women beyond the age of 18. As a result, it is more likely that newborns eligible for CHIP are not covered from the moment of birth, and therefore, often miss having comprehensive prenatal care and those first critical months of life until their CHIP application is processed.

By expanding coverage to pregnant women through CHIP, the ''Start Healthy, Stay Healthy Act'' recognizes the importance of prenatal care to the health and development of a child. As Dr. Alan Waxman of the University of New Mexico School of Medicine has written, ''Prenatal care is an important factor in the prevention of birth defects and the prevention of prematurity, the most common causes of infant death and disability. Babies born to women with no prenatal care or late prenatal care are nearly twice as likely to [be] low birthweight or very low birthweight as infants born to women who received early prenatal care.''

Unfortunately, according to the Centers for Disease Control and Prevention, New Mexico ranked worst in the Nation in the percentage of mothers receiving late or no prenatal care last year. The result is often quite costly—both in terms of the health of the mother and newborn but also in terms of the long-term expenses since the result can be chronic, lifelong health problems.

In fact, according to the Agency for Healthcare Research and Quality, ''four of the top 10 most expensive conditions in the hospital are related to care of infants with complications (respiratory distress, prematurity, heart defects, and lack of oxygen).'' As a result, in addition to reduced infant mortality and morbidity, the provision to expand coverage to pregnant women can be cost effective.

The ''Start Healthy, Stay Healthy Act'' also eliminates the unintended federal policy through CHIP that covers pregnant women only through the age of 18 and cuts off that coverage once the women turn 19 years of age. Certainly, everybody can agree that the government should not be telling women that they are more likely to receive prenatal care coverage only if they become pregnant as a teenager.

This bipartisan legislation has previously received or has added endorsements from the following organizations: the March of Dimes, The American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the What to Expect Foundation, the American Academy of Family Physicians, the American Academy of Pediatric Dentistry, the American Academy of Child and Adolescent Psychiatry, the National Association of Community Health Centers, the American Hospital Association, the National Association of Children's Hospitals, the Federation of American Health Systems, the National Association of Public Hospitals and Health Systems, Premier, Catholic Health Association, Catholic Charities USA, Family Voices, the Association of Maternal and Child Health Programs, the National Health Law Program, the National Association of Social Workers, Every Child By Two, the United Cerebral Palsy Associations, the Society for Maternal-Fetal Medicine, and Families USA.

This legislation is a reintroduction of a bill that was introduced in 2001. Throughout that year, the Administration made numerous statements in support of the passage of this type of legislation, but unfortunately, reversed course in October 2002 after publishing a regulation allowing states to redefine a ''child'' as an ''unborn child'' and to provide prenatal care through CHIP in that manner. In a letter to Senator NICKLES dated October 8, 2002, Secretary Thompson argued, ''I believe the regulation is a more effective and comprehensive solution to this issue.''

While a number of senators strongly disagreed with Secretary Thompson's assertion and sent him letters to that effect on October 10, 2002, and on October 23, 2002, we felt it was important to get the testimony of our Nation's medical experts on the health and well-being of both pregnant women and newborns. We called for a hearing in the Senate Health, Education, Labor and Pensions Committee on October 24, 2002. Witnesses included representatives from the March of Dimes, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the What to Expect Foundation. They were asked to compare the regulation to the legislation and I will let their testimony speak for itself.

Dr. Nancy Green testified on behalf of the March of Dimes Birth Defects Foundation. She said:

> We support giving states the flexibility they need to cover income-eligible pregnant women age 19 and older, and to automatically enroll infants born to SCHIP-eligible mothers. By establishing a uniform eligibility threshold for coverage for pregnant women and infants, states will be able to improve maternal health, eliminate waiting periods for infants and streamline administration of publicly supported health programs. Currently, according to the Department of Health and Human Services' Centers for Medicare and Medicaid Services and the National Governors' Association, 36 states and the District of Columbia have income eligibility thresholds that are more restrictive for women than for their newborns. Encouraging states to eliminate this disparity by allowing them to establish a uniform eligibility threshold for pregnant women and their infants should be a national policy priority.

Dr. Green adds:

> Specifically, we are deeply concerned that final regulation fails to provide to the mother the standard scope of maternity care services recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). Of particular concern, the regulation explicitly states that postpartum care is not covered and, therefore, federal reimbursement will not be available for these services. In addition, because of the contentious collateral issues raised by this regulation groups like the March of Dimes will find it even more difficult to work in the states to generate support for legislation to extend coverage to uninsured pregnant women.

Dr. Laura Riley testified on behalf of ACOG. In her testimony, she stated:

> ACOG is very concerned that mothers will not have access to postpartum services under the regulation. The rule clearly states that ''. . . care after delivery, such as postpartum services could not be covered as part of the Title XXI State Plan . . . because they are not services for an eligible child.''

On the importance of postpartum care, Dr. Riley adds:

When new mothers develop postpartum complications, quick access to their physicians is absolutely critical. Postpartum care is especially important for women who have preexisting medical conditions, and for those whose medical conditions were induced by their pregnancies, such as gestational diabetes or hypertension, and for whom it is necessary to ensure that their conditions are stabilized and treated.

As a result, Dr. Riley concludes:

Limiting coverage to the fetus instead of the mother omits a critical component of postpartum care that physicians regard as essential for the health of the mother and the child. Covering the fetus as opposed to the mother also raises questions of whether certain services will be available during pregnancy and labor if the condition is one that more directly affects the woman. The best way to address this coverage issue is to pass S. 724, supported by Senators Bond, Bingaman and Lincoln and many others, and which provides a full range of medical services during and after pregnancy directly to the pregnant woman.

Dr. Richard Bucciarelli testified on behalf of the American Academy of Pediatrics. He said:

Recently, the Administration published a final rule expanding SCHIP cover unborn children. The Academy is concerned that, as written, this regulation falls dangerously short of the clinical standards of care outlined in our guidelines, which describe the importance of covering all stages of a birth—pregnancy, delivery, and postpartum care.

It is important to note that the regulation subtracts the time that an ''unborn child'' is covered from the period of continuously eligibility after birth. Consequently, children would be denied insurance coverage at very critical points during the first full year of life. As such, Dr. Bucciarelli expressed support for the legislation over the regulation because it, in his words:

. . . takes an important step to decrease the number of uninsured children by providing 12 months of continuous eligibility for those children born. . . . This legislation ensures that children born to women enrolled in Medicaid or SCHIP are immediately enrolled in the program for which they are eligible. Additionally, this provision prevents newborns eligible for SCHIP from being subject to enrollment waiting periods, ensuring that infants receive appropriate health care in their first year of life.

And finally, Lisa Bernstein testified as Executive Director of The What to Expect Foundation, which takes its name from the bestselling What to Expect pregnancy and parenting series that has helped over 20 million families from pregnancy through their child's toddler years. Ms. Bernstein also supported the legislation as a far superior option over the regulation and make this simple but eloquent point:

. . . only a healthy parent can provide a healthy future for a healthy child.

The testimony of these experts speak for themselves and I urge my colleagues to pass this legislation as soon as possible.

I ask unanimous consent that the text of the bill and a series of letters be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1033

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Start Healthy, Stay Healthy Act of 2003''.

SEC. 2. STATE OPTION TO EXPAND OR ADD COVERAGE OF CERTAIN PREGNANT WOMEN UNDER MEDICAID AND SCHIP.

(a) MEDICAID.—

(1) AUTHORITY TO EXPAND COVERAGE.—Section 1902(l)(2)(A)(i) of the Social Security Act (42 U.S.C. 1396a(l)(2)(A)(i)) is amended by inserting ''(or such higher percent as the State may elect for purposes of expenditures for medical assistance for pregnant women described in section 1905(u)(4)(A))'' after ''185 percent''.

(2) ENHANCED MATCHING FUNDS AVAILABLE IF CERTAIN CONDITIONS MET.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(A) in the fourth sentence of subsection (b), by striking ''or subsection (u)(3)'' and inserting '', (u)(3), or (u)(4)''; and

(B) in subsection (u)—

(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following:

''(4) For purposes of the fourth sentence of subsection (b) and section 2105(a), the expenditures described in this paragraph are the following:

''(A) CERTAIN PREGNANT WOMEN.—If the conditions described in subparagraph (B) are met, expenditures for medical assistance for pregnant women described in subsection (n) or under section 1902(l)(1)(A) in a family the income of which exceeds the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) that has been specified under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902, as of January 1, 2003, but does not exceed the income eligibility level established under title XXI for a targeted low-income child.

''(B) CONDITIONS.—The conditions described in this subparagraph are the following:

''(i) The State plans under this title and title XXI do not provide coverage for pregnant women described in subparagraph (A) with higher family income without covering such pregnant women with a lower family income.

''(ii) The State does not apply an effective income level for pregnant women that is lower than the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) that has been specified under the State plan under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902, as of January 1, 2003, to be eligible for medical assistance as a pregnant woman.

''(C) DEFINITION OF POVERTY LINE.—In this subsection, the term 'poverty line' has the meaning given such term in section 2110(c)(5).''.

(3) PAYMENT FROM TITLE XXI ALLOTMENT FOR MEDICAID EXPANSION COSTS; ELIMINATION OF COUNTING MEDICAID CHILD PRESUMPTIVE ELIGIBILITY COSTS AGAINST TITLE XXI ALLOTMENT.—Section 2105(a)(1) of the Social Security Act (42 U.S.C. 1397ee(a)(1)) is amended—

(A) in the matter preceding subparagraph (A), by striking ''(or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)))''; and

(B) by striking subparagraph (B) and inserting the following:

''(B) for the provision of medical assistance that is attributable to expenditures described in section 1905(u)(4)(A);''.

(4) ADDITIONAL AMENDMENTS TO MEDICAID.—

(A) ELIGIBILITY OF A NEWBORN.—Section 1902(e)(4) of the Social Security Act (42 U.S.C. 1396a(e)(4)) is amended in the first sentence by striking ''so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance''.

(B) APPLICATION OF QUALIFIED ENTITIES TO PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN UNDER MEDICAID.—Section 1920(b) of the Social Security Act (42 U.S.C. 1396r–1(b)) is amended by adding at the end after and below paragraph (2) the following flush sentence:

''The term 'qualified provider' includes a qualified entity as defined in section 1920A(b)(3).''.

(b) SCHIP.—

(1) COVERAGE.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 2111. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN.

''(a) OPTIONAL COVERAGE.—Notwithstanding any other provision of this title, a State may provide for coverage, through an amendment to its State child health plan under section 2102, of pregnancy-related assistance for targeted low-income pregnant women in accordance with this section, but only if the State meets the conditions described in section 1905(u)(4)(B).

''(b) DEFINITIONS.—For purposes of this title:

''(1) PREGNANCY-RELATED ASSISTANCE.—The term 'pregnancy-related assistance' has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income pregnant women, except that the assistance shall be limited to services related to pregnancy (which include prenatal, delivery, and postpartum services and services described in section 1905(a)(4)(C)) and to other conditions that may complicate pregnancy.

''(2) TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' means a woman—

''(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

''(B) whose family income exceeds the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) that has been specified under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902, as of January 1, 2003, to be eligible for medical assistance as a pregnant woman under title XIX but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and

''(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of section 2110(b).

''(c) REFERENCES TO TERMS AND SPECIAL RULES.—In the case of, and with respect to, a State providing for coverage of pregnancy-related assistance to targeted low-income pregnant women under subsection (a), the following special rules apply:

''(1) Any reference in this title (other than in subsection (b)) to a targeted low-income child is deemed to include a reference to a targeted low-income pregnant woman.

''(2) Any such reference to child health assistance with respect to such women is deemed a reference to pregnancy-related assistance.

''(3) Any such reference to a child is deemed a reference to a woman during pregnancy and the period described in subsection (b)(2)(A).

''(4) In applying section 2102(b)(3)(B), any reference to children found through screening to be eligible for medical assistance under the State medicaid plan under title XIX is deemed a reference to pregnant women.

''(5) There shall be no exclusion of benefits for services described in subsection (b)(1) based on any preexisting condition and no waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) shall apply.

''(6) Subsection (a) of section 2103 (relating to required scope of health insurance coverage) shall not apply insofar as a State limits coverage to services described in subsection (b)(1) and the reference to such section in section 2105(a)(1)(C) is deemed not to require, in such case, compliance with the requirements of section 2103(a).

''(7) In applying section 2103(e)(3)(B) in the case of a pregnant woman provided coverage under this section, the limitation on total annual aggregate cost-sharing shall be applied to the entire family of such pregnant woman.

''(d) AUTOMATIC ENROLLMENT FOR CHILDREN BORN TO WOMEN RECEIVING PREGNANCY-RELATED ASSISTANCE.—If a child is born to a targeted low-income pregnant woman who was receiving pregnancy-related assistance under this section on the date of the child's birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under title XIX and to have been found eligible for such assistance under such title, as appropriate, on the date of such birth and to remain eligible for such assistance until the child attains 1 year of age. During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the child health or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).''.

(2) ADDITIONAL ALLOTMENTS FOR PROVIDING COVERAGE OF PREGNANT WOMEN.—

(A) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by inserting after subsection (c) the following:

''(d) ADDITIONAL ALLOTMENTS FOR PROVIDING COVERAGE OF PREGNANT WOMEN.—

''(1) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing additional allotments to States under this title, there is appropriated, out of any money in the Treasury not otherwise appropriated, for each of fiscal years 2004 through 2007, $200,000,000.

''(2) STATE AND TERRITORIAL ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraphs (3) and (4), of the amount available for the additional allotments under paragraph (1) for a fiscal year, the Secretary shall allot to each State with a State child health plan approved under this title—

''(A) in the case of such a State other than a commonwealth or territory described in subparagraph (B), the same proportion as the proportion of the State's allotment under subsection (b) (determined without regard to subsection (f)) to the total amount of the allotments under subsection (b) for such States eligible for an allotment under this paragraph for such fiscal year; and

''(B) in the case of a commonwealth or territory described in subsection (c)(3), the same proportion as the proportion of the commonwealth's or territory's allotment under subsection (c) (determined without regard to subsection (f)) to the total amount of the allotments under subsection (c) for commonwealths and territories eligible for an allotment under this paragraph for such fiscal year.

''(3) USE OF ADDITIONAL ALLOTMENT.—Additional allotments provided under this subsection are not available for amounts expended before October 1, 2003. Such amounts are available for amounts expended on or after such date for child health assistance for targeted low-income children, as well as for pregnancy-related assistance for targeted low-income pregnant women.

''(4) NO PAYMENTS UNLESS ELECTION TO EXPAND COVERAGE OF PREGNANT WOMEN.—No payments may be made to a State under this title from an allotment provided under this subsection unless the State provides pregnancy-related assistance for targeted low-income pregnant women under this title, or provides medical assistance for pregnant women under title XIX, whose family income exceeds the effective income level applicable under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902 to a family of the size involved as of January 1, 2003.''.

(B) CONFORMING AMENDMENTS.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended—

(i) in subsection (a), in the matter preceding paragraph (1), by inserting ''subject to subsection (d),'' after ''under this section,'';

(ii) in subsection (b)(1), by inserting ''and subsection (d)'' after ''Subject to paragraph (4)''; and

(iii) in subsection (c)(1), by inserting ''subject to subsection (d),'' after ''for a fiscal year,''.

(3) PRESUMPTIVE ELIGIBILITY UNDER TITLE XXI.—

(A) APPLICATION TO PREGNANT WOMEN.—Section 2107(e)(1)(D) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended to read as follows:

''(D) Sections 1920 and 1920A (relating to presumptive eligibility).''.

(B) EXCEPTION FROM LIMITATION ON ADMINISTRATIVE EXPENSES.—Section 2105(c)(2) of the Social Security Act (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following new subparagraph:

''(C) EXCEPTION FOR PRESUMPTIVE ELIGIBILITY EXPENDITURES.—The limitation under subparagraph (A) on expenditures shall not apply to expenditures attributable to the application of section 1920 or 1920A (pursuant to section 2107(e)(1)(D)), regardless of whether the child or pregnant woman is determined to be ineligible for the program under this title or title XIX.''.

(4) ADDITIONAL AMENDMENTS TO TITLE XXI.—

(A) NO COST-SHARING FOR PREGNANCY-RELATED SERVICES.—Section 2103(e)(2) of the Social Security Act (42 U.S.C. 1397cc(e)(2)) is amended—

(i) in the heading, by inserting ''OR PREGNANCY-RELATED SERVICES'' after ''PREVENTIVE SERVICES''; and

(ii) by inserting before the period at the end the following: ''or for pregnancy-related services''.

(B) NO WAITING PERIOD.—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(i) by striking '', and'' at the end of clause (i) and inserting a semicolon;

(ii) by striking the period at the end of clause (ii) and inserting ''; and''; and

(iii) by adding at the end the following:

''(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income pregnant woman.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after October 1, 2003, without regard to whether regulations implementing such amendments have been promulgated.

SEC. 3. COORDINATION WITH THE MATERNAL AND CHILD HEALTH PROGRAM.

(a) IN GENERAL.—Section 2102(b)(3) of the Social Security Act (42 U.S.C. 1397bb(b)(3)) is amended—

(1) in subparagraph (D), by striking ''and'' at the end;

(2) in subparagraph (E), by striking the period and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F) that operations and activities under this title are developed and implemented in consultation and coordination with the program operated by the State under title V in areas including outreach and enrollment, benefits and services, service delivery standards, public health and social service agency relationships, and quality assurance and data reporting.''.

(b) CONFORMING MEDICAID AMENDMENT.—Section 1902(a)(11) of such Act (42 U.S.C. 1396a(a)(11)) is amended—

(1) by striking ''and'' before ''(C)''; and

(2) by inserting before the semicolon at the end the following: '', and (D) provide that operations and activities under this title are developed and implemented in consultation and coordination with the program operated by the State under title V in areas including outreach and enrollment, benefits and services, service delivery standards, public health and social service agency relationships, and quality assurance and data reporting''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2004.

SEC. 4. INCREASE IN SCHIP INCOME ELIGIBILITY.

(a) DEFINITION OF LOW-INCOME CHILD.—Section 2110(c)(4) of the Social Security Act (42 U.S.C. 42 U.S.C. 1397jj(c)(4)) is amended by striking ''200'' and inserting ''250''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to child health assistance provided, and allotments determined under section 2104 of the Social Security Act (42 U.S.C. 1397dd), for fiscal years beginning with fiscal year 2004.

SEC. 5. REVIEW OF STATE AGENCY BLINDNESS AND DISABILITY DETERMINATIONS.

Section 1633 of the Social Security Act (42 U.S.C. 1383b) is amended by adding at the end the following:

''(e)(1) The Commissioner of Social Security shall review determinations, made by State agencies pursuant to subsection (a) in connection with applications for benefits under this title on the basis of blindness or disability, that individuals who have attained 18 years of age are blind or disabled as of a specified onset date. The Commissioner of Social Security shall review such a determination before any action is taken to implement the determination.

''(2)(A) In carrying out paragraph (1), the Commissioner of Social Security shall review—

''(i) at least 25 percent of all determinations referred to in paragraph (1) that are made in fiscal year 2004; and

''(ii) at least 50 percent of all such determinations that are made in fiscal year 2005 or thereafter.

''(B) In carrying out subparagraph (A), the Commissioner of Social Security shall, to the extent feasible, select for review the determinations which the Commissioner of Social Security identifies as being the most likely to be incorrect.''.

THE SECRETARY OF HEALTH
AND HUMAN SERVICES,
Washington, DC, April 12, 2002.

Hon. JEFF BINGAMAN,
U.S. Senate,
Washington, DC.

DEAR SENATOR BINGAMAN: Thank you for sharing your views on our new proposal to expand health care coverage for low-income pregnant women under the State Children's Health Insurance Program (SCHIP). I believe it is not only appropriate, but indeed, medically necessary that our approach to child health care include the prenatal stage.

Prenatal care for women and their babies is a crucial part of medical care. These services can be a vital, life-long determinant of health, and we should do everything we can to make this care available for all pregnant women. It is one of the most important investments we can make for the long-term good health of our nation.

Our regulation would enable states to make use of funding already available under SCHIP to provide prenatal care for more low-income pregnant women and their babies. The proposed regulation, published in the FEDERAL REGISTER March 5, would clarify the definition of ''child'' under the SCHIP program. At present, SCHIP allows states to provide health care coverage to targeted low-income children under age 19. States may further limit their coverage to age groups within that range. The new regulation would clarify that states may include coverage for children from conception to age 19, enabling SCHIP coverage to include prenatal and delivery care to ensure the birth of healthy infants.

Although Medicaid currently provides coverage for prenatal care for some women with low incomes, implementing this new regulation will allow states to offer such coverage to additional women. States would not be required to go through the section 1115 waiver process to expand coverage for prenatal care.

By explicitly recognizing in our SCHIP regulations the health needs of children before birth, we can help states provide vital prenatal health care. I believe our approach is entirely appropriate to serve these health purposes. It has been an option for states in their Medicaid programs in the past and it should be made an option for states in their SCHIP program now. As I testified recently at a hearing held by the Health Subcommittee of the House Energy and Commerce Committee, I also support legislation to expand SCHIP to cover pregnant women. However, because legislation has not moved and because of the importance of prenatal care, I felt it was important to take this action.

I know we share the same commitment to achieving the goal of expanding health insurance coverage in order to reduce the number of uninsured.

A similar letter is being sent to the cosigners of your letter. Please feel free to call me if you have any questions or concerns.

Sincerely,

TOMMY G. THOMPSON.

THE SECRETARY OF HEALTH
AND HUMAN SERVICES,
Washington, DC, October 8, 2002.

Hon. DON NICKLES,
Assistant Republican Leader,
Washington, DC.

DEAR SENATOR NICKLES: Thank you for contacting me about the Department of Health and Human Services' final regulation to expand pre-natal and pregnancy related services to unborn children under the State Children's Health Insurance Program (SCHIP).

The final rule allows states the option to extend such services under SCHIP to low-income pregnant women and their unborn children immediately. The rule also enables states to cover a broader population of low-income women and children because it extends coverage to unborn children regardless of their mothers' immigrant status.

In your letter, you ask if ''this regulation has obviated the need for additional legislation, and has addressed this issue in a more timely and effective manner.'' As I have stated many times this year, my overarching goal has been to extend prenatal and pregnancy related services to low-income women and their children as quickly as possible so that those mothers are cared for during their pregnancy and their children are born healthy and strong. The law provided me the flexibility to do that and I believe the rule that was published this week achieves this universally desired goal. The proposed legislation, which has been pending in Congress for some time, would amend the SCHIP law so as to duplicate what we have already established as administration policy. I believe the regulation is a more effective and comprehensive solution to this issue. Therefore, there is no need for the Senate to pursue this legislation now.

Thank you for inquiring on this important policy matter.

Sincerely,

TOMMY G. THOMPSON.

U.S. SENATE,
Washington, DC, October 10, 2002.

Hon. TOMMY THOMPSON,
Secretary, Department of Health and Human Services, Washington, DC.

DEAR SECRETARY THOMPSON: Over the course of the past year, you have issued press releases, written letters, and responded to direct questions in both Senate and House hearings in support of passing legislation to provide health care coverage to pregnant women through the State Children's Health Insurance Program (SCHIP). You have repeatedly stated that you were proceeding with the regulation to expand SCHIP to ''unborn children'' only because legislation to expand coverage to pregnant women had not passed.

Your own regulation explicitly makes that very point and acknowledges that ''gaps remain'' and that a number of important health services for pregnant women, including postpartum care, are not provided for in the regulation. And yet, we now read in a letter from you to Senator Nickles dated October 8, 2002, that the ''gaps'' have somehow disappeared. As you write, ''The proposed legislation, which has been pending in Congress for some time, would amend the SCHIP law so as to duplicate what we have already established as administration policy. I believe the regulation is a more effective and comprehensive solution to this issue. Therefore, there is no need for the Senate to pursue this legislation now.''

Yet, your own regulation contradicts that statement and notes that ''there are still gaps'' and repeatedly points out those coverage gaps for pregnant women and children. With respect to care for women, under the regulation, it is explicitly stated that ''there must be a connection between the benefits provided and the health of the unborn child.'' A whole range of health services to pregnant women during pregnancy and delivery could be potentially denied as a result. In the case of epidurals, for example, the best the regulation can say is that you ''expect'' coverage.

For postpartum care, the regulation explicitly states that any care during that period, including but not limited to hemorrhage, infection, episiotomy repair, C-section repair, family planning counseling, treatment of complications after delivery (including life-saving surgery), and postpartum depression, would be denied. As the regulation reads, ''Commenters are correct that care after delivery, such as postpartum services could not be covered as part of [SCHIP], (unless the mother is under age 19 and eligible for SCHIP in her own right), because they are not services for an eligible child.''

According to the Centers for Disease Control and Prevention (CDC), the United States ranks 21st in the world in maternal mortality. The major causes of which were hemorrhage, ectopic pregnancy, pregnancy-induced hypertension, embolism, infection, and other complications of pregnancy and childbirth. Again, health coverage for many of these conditions is denied under the regulation but not in S. 724. How then do you argue the regulation is ''more effective and comprehensive'' and that the legislation is ''duplicat[ive]'' of the regulation with respect to care for pregnant women?

With respect to coverage of children, under the regulation, the 12-month continuous eligibility for children is not from the time of birth but the clock begins running during the time of coverage prior to birth. S. 724 provides comprehensive pediatric care to children throughout the first and most fragile year of life. In contrast, for prenatal care delivered to an ''unborn child'' under this regulation, that time is subtracted from the 12-month period after birth. Therefore, under the regulation, if nine months of prenatal care are provided, the child could lose coverage at the end of the 3rd month after birth. Potentially lost would be a number of important well-baby visits, immunizations, and access to their pediatric caregiver. Once again, how then do you argue the regulation is ''more effective and comprehensive'' and that the legislation is ''duplicat[ative]'' to the regulation for children?

Furthermore, according to the rule, the Administration estimates that only 13 states will elect to adopt this definition to include ''unborn children'' in their SCHIP state plans. The other 37 states will either not expand SCHIP to provide prenatal care to additional populations or be forced to seek a federal waiver to also cover pregnant women, as Colorado did just two weeks ago. However, the regulation was right on the mark in stating that it is ''an inferior option'' to require states to have to get waivers to provide the full range of care to pregnant women and 12-month continuous eligibility for children after birth.

As the regulation reads, ''. . . the Secretary's ability to intervene through one mechanism (a waiver) should not be the sole option for States and may in fact be an inferior option. Waivers are discretionary on the part of the Secretary and time limited while State plan amendments are permanent, and are subject to budget neutrality.'' For a third time, how can you now argue, less than a week after issuing the regulation, that it is ''more effective and comprehensive'' than the legislation?

The States agree, as you know. The National Governors' Association has clear policy expressing support for the passage of such legislation. As their policy position (HR–15. ''The State Children's Health Insurance Program (S–CHIP) Policy'') reads:

''The Governors have a long tradition of expanding coverage options for pregnant women through the Medicaid program. However, pregnant women in working families are not eligible for SCHIP coverage. The Governors call on Congress to create a state option that would allow states to provide health coverage to income-eligible pregnant women under SCHIP. This small shift in federal policy would allow states to provide critical prenatal care and would increase the likelihood that children born to SCHIP mothers would have a healthy start.''

Finally, unlike S. 724, the regulation provides absolutely no additional resources (despite estimating the cost to be $330 million over the next five years) for covering ''unborn children'' and certain pregnancy-related services. Current projections by the Office of Management and Budget indicate that SCHIP funds will ultimately be inadequate to cover all the children currently enrolled, even though millions of additional children are eligible but not currently covered. In sharp contrast, just as S. 724 does, we must provide adequate resources to serve both low-income children and low-income pregnant women.

Mr. Secretary, just as you said in your press release on January 31, 2002, we also praise Senators Bond, Breaux, and Collins for ''bipartisan leadership in supporting S. 724, a bill that would allow states to provide prenatal coverage for low-income women through the SCHIP program. We support this legislative effort in this Congress.'' We agreed with you on January 31, 2002, and hope that you will once again support the passage of S. 724, the ''Mothers and Newborns Health Insurance Act.''

We eagerly await your response to this very important matter with respect to the health and well-being of our nation's children and mothers.

Sincerely,

Jeff Bingaman, Jon Corzine, Edward M. Kennedy, Maria Cantwell, Hillary Rodham Clinton, Dianne Feinstein, Blanche L. Lincoln, Mary Landrieu, Patty Murray, James M. Jeffords, John B. Breaux, Jack Reed, Patrick J. Leahy, Barbara A. Mikulski, Charles E. Schumer.

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, October 15, 2002.

Hon. JEFF BINGAMAN,
U.S. Senate,
Washington, DC.

DEAR SENATOR BINGAMAN: Thank you for your letter of last week and your continued interest in finding effective ways to increase prenatal coverage.

I have frequently stated in the past that my chief objective in proposing the rule to extend coverage to unborn children was to ensure that pregnant women and children who are currently ineligible for health care under either Medicaid or S–CHIP are given the support they need for a healthy pregnancy and a safe delivery. This is clearly a goal we share. When asked my position on pending legislation earlier this year, I expressed general support because my overriding interest and concern has always been to provide prenatal care to more women and children. If legislation could provide that coverage more expeditiously, then it seemed to me it would be advantageous to women and children to see that go forward.

However, despite years of committed effort by you and other members, Congress has yet to move legislation through the process. Legislation was introduced in the 106th Congress but was never reported out of Committee in either the House or Senate. In this current Congress, the Senate Finance Committee reported S. 724 in early August of this year, but no floor time was scheduled for its consideration. Consequently, after seven months without any legislative action, I issued a final regulation.

Last year, when I saw that I had the authority under current law to provide prenatal and delivery care to low-income pregnant mothers and their unborn children, I was excited because I realized the Department could accomplish what we all wish to achieve: helping those children get a healthy start in life. A great deal of thought went into the regulation and, with the exception of postpartum care after hospitalization, we were able to give the states the same flexibility the would have under the proposed legislation to provide prenatal and delivery care to unborn children and their mothers.

Under current law, however, we have the authority to grant waivers that include coverage for women if they become pregnant, including postpartum care. Since January 2001, I have granted approval to a number of states to allow for expanded health insurance coverage through comprehensive 1115 waivers, which also include postpartum care. In fact, this summer I approved a waiver for New Mexico which included prenatal care, labor and delivery, and postpartum care. This regulation simply adds to the options available to the states in expanding health insurance coverage.

In addition to making it possible for states to use federal funds to provide the prenatal and pregnancy-related coverage options available under S. 724, the regulation provides additional opportunities and assistance for states to reach low-income women. For example, under the regulation, we were able to reach an even broader population of vulnerable women and children because we could offer prenatal care to the children of immigrants who are otherwise ineligible for any coverage. The establishment of eligibility regardless of immigrant status is possible under the regulation but not under S. 724, making the regulation more comprehensive. I am sure you appreciate the importance of the new opportunity to provide prenatal care and pregnancy-related services to immigrant mothers, given the substantial immigrant population in New Mexico.

Additionally, the regulation provides more opportunities for states to access enhanced-match funds than S. 724. Under the bill, states with current eligibility levels for pregnant women below 185 percent of poverty would not be eligible for the enhanced match until they raised their eligibility at their regular match rate. States have already had the option to raise eligibility for pregnant women at their regular match rate, but many have not done so. Thus, we expect that many states will not expand prenatal coverage under S. 724. However, access to enhanced-match funds under the regulation will provide them a more affordable opportunity to do so.

With regard to specific criticisms of the rule, you have raised concerns about the reference in the S–CHIP regulation to ''gaps.'' It is important to put the use of the term ''gaps'' in the proper context. This reference is to the eleigbility gap between Medicaid and S–CHIP, which the regulation and S. 724 both seek to close. The response in the regulation does not refer to benefits, so the reference in your recent letter that ''gaps remain'' is taken out of context and, in fact, an incorrect referencing of the regulation.

Under both the regulation and the legislation, the states ultimately determine the benefit package. That feature of your legislation does not differ from the rule. And, we have clearly indicated federal funds will be available for services including prenatal care and labor and delivery. Your letter makes assumptions regarding medical services during pregnancy and delivery that HHS does not. The letter confuses medical decisions that are made by physicians with payment of claims under a public assistance program. The regulation is used to establish eligibility for benefits and does not itself extend into medical decision-making between a woman and her physician. HHS responded to a number of questions regarding services and clearly indicated federal financial participation would be available. There is no need to further question whether a claim for a service already provided will receive federal matching funds.

The issue of 12 months continuous eligibility is an option for the states. Under the regulation, states that want to extend eligibility can easily do so.

I hope this explanation of the regulation and where it extends beyond the reach of S. 724 will give you confidence in our policy and it's ability to meet the ultimate goal that you and I have worked over the years to meet. You are due a large measure of credit for your efforts on behalf of low-income women and their children. The regulation is a victory for those women and children and will give otherwise uncovered needy mothers and their babies a healthy start in life.

Sincerely,

TOMMY G. THOMSPON.

U.S. SENATE,
Washington, DC, October 23, 2002.

Hon. TOMMY THOMPSON,
Secretary, Department of Health and Human Services, Washington, DC.

DEAR SENATOR THOMPSON: Thank you for your letter yesterday with regard to improving health coverage for pregnant women and children. We appreciate your stated desire to ''give otherwise uncovered needy mothers and their babies a healthy start in life'' by adding ''to the options available to the states in expanding health insurance options.'' We believe we can take the best aspects of the legislation and the regulation to truly improve the health and well-being of our nation's children and mothers.

In light of the fact that our nation ranks 26th in infant mortality and 21st in maternal mortality in the world, which is the worst among developed nations, we would be remiss to not take the simple but critical step of increasing access to prenatal, delivery, and postpartum care through the State Children's Health Insurance Program (SCHIP) to help prevent birth defects and prematurity, the most common causes of infant death and disability, and maternal death and disability.

As your letter acknowledges, postpartum care is not covered under the regulation. This gap in coverage includes a range of critical care for women, including potentially life-saving postpartum care for hemorrhage, pregnancy-induced hypertension, infection, ectopic pregnancy, embolism, episiotomy repair, Caesarean section repair, family planning counseling, postpartum depression, and other complications of pregnancy and childbirth. In fact, according to the National Committee for Quality Assurance (NCQA), ''Hemorrhage, pregnancy-induced hypertension, infection, and ectopic pregnancy continue to account for more than half of all maternal deaths (59 percent).''

According to the Centers for Disease Control and Prevention (CDC), there were 3,193 pregnancy-related deaths in this country between 1991 and 1997 for an overall pregnancy-related mortality ratio (PRMR) of 11.5 per 100,000 live births. Racial disparities are rather dramatic with respect to maternal mortality. African-American women had mortality rates over four times higher than that of non-Hispanic whites over the period. American Indian/Alaska Natives, Asian/Pacific Islanders, and Hispanic women had mortality rates 67 percent, 55 percent, and 41 percent, respectively, higher than non-Hispanic whites.

Those disparities are even more pronounced in some states. For example, in Wisconsin, the maternal mortality rate for African-American women was 4.2 times that of white women between 1987 and 1996. Certainly, this is something that we can all agree should be addressed.

To allow states the option to provide comprehensive coverage to pregnant women, including postpartum care, through SCHIP would help achieve that important goal. S. 724, the ''Mothers and Newborns Health Insurance Act,'' gives states that important coverage option while the regulation does not.

While your letter correctly notes that states may receive comprehensive 1115 waivers to provide coverage to pregnant women, your regulation is correct in noting that is an inferior option. As the regulation reads, ''. . . the Secretary's ability to intervene through one mechanism (a waiver) should not be the sole option for States and may in fact be an inferior option. Waivers are discretionary on the part of the Secretary and time limited while State plan amendments are permanent, and are subject to budget neutrality.'' We should remove those barriers and give states the option to provide pregnant women coverage without having to seek waivers.

We would add that the waiver option is allowed for the purposes of giving the Secretary demonstration authority. We certainly can all acknowledge that coverage of pregnant women has reduced both infant mortality and maternal mortality and need not be demonstrated any further. The waiver process seems inappropriate for this purpose. Instead, we should remove those barriers for states to provide comprehensive coverage to pregnant women. As the National Governors' Association has stated in its policy (HR–15. ''The State Children's Health Insurance Program (S–CHIP) Policy''): The Governors call on Congress to create a state option that would allow states to provide health coverage to income-eligible women under SCHIP. This small shift in federal policy would allow states to provide critical prenatal care and would increase the likelihood that children born to SCHIP mothers would have a healthy start.

Just as the governors have requested, we can still make that ''small shift'' in policy through the passage of S. 724.

As for the coverage of infants, your letter did not address the issues raised in a previous letter to you from 15 senators, including many of us, dated October 10, 2002. Your letter restates the fact that states have the option to provide children 12 months of continuous eligibility in Medicaid and SCHIP. However, under the regulation, the 12-month continuous eligibility for children is not from the time of birth. Rather, the clock begins running during the time of coverage prior to birth. Thus, it is likely that most newborns would have far less than 12 months of coverage after birth if a State chooses to use the option to provide care to ''unborn children.'' If covered for the full nine months of pregnancy, the child could lose eligibility for SCHIP after the third month of life and consequently lose important coverage for well-baby visits, immunizations, and access to their pediatric caregiver. That would be an outright reduction of coverage for some children after birth.

We would note that the legislation continues to have the strong support of a number of groups, including some who support the regulation but acknowledge its shortcomings and continue to support passing legislation. Those groups include the American Association of University Affiliated Programs, the American Academy of Pediatrics, the American College of Nurse Midwives, the American College of Obstetrics and Gynecologists, the American Hospital Association, the American Medical Association, the American Public Health Association, the Association of Women's Health, Obstetric and Neonatal Nurses, the Association of Maternal and Child Health Programs, the Catholic Health Association, Catholic Charities USA, the Council of Women's and Infants' Specialty Hospitals, the Easter Seals, FamilyVoices, the March of Dimes, the National Association of Children's Hospitals, the National Association of Public Hospitals and Health Systems, the National Women's Health Network, the National Association of County and City Health Officials, the Society for Maternal-Fetal Medicine, the Spina Bifida Association of America, the Alan Guttmacher Institute, and the United Cerebral Palsy Associations.

There are certainly areas where the regulation is more comprehensive than the legislation, such as providing coverage to the ''unborn children'' of immigrant mothers and by providing states easier access to enhanced matching funds. We believe we could certainly amend S. 724 to address these shortcomings rather easily. It would be easy to drop the requirement in the bill for a state to expand eligibility to 185 percent of poverty before receiving the enhanced matching rate. However, this begs the question about the need for providing additional resources in SCHIP to cover these options. Current projections by the Office of Management and Budget indicate that SCHIP funds will ultimately be inadequate to cover all the children currently enrolled, even though millions of additional children are eligible but not currently covered. S. 724 provides such funding, which the regulation does not and cannot.

In short, we believe that we can rather quickly achieve the best of both the legislation and the regulation. S. 724 expands state options to cover critically important postpartum services for women, ensures children are eligible for coverage throughout the first and most critical year of life, and provides much needed resources to provide such care. In contrast, the regulation provides states with more opportunities to access enhanced matching funds and provides certain prenatal care services to immigrant mothers that S. 724 does not provide.

We would like to arrange a meeting with you or your staff to jointly modify S. 724 to address, as best as we can, the concerns we have discussed above and that you have raised with the legislation to accomplish the objective we all share of improving the health and well-being of out nation's children and mothers.

Sincerely,

Jeff Bingaman. Blanche L. Lincoln. Jon Corzine. Maria Cantwell. Patty Murray. Mary Landrieu. James M. Jeffords. Edward M. Kennedy. Hillary Rodham Clinton. Charles E. Schumer. John F. Kerry. John R. Edwards. Daniel K. Akaka. Jack Reed. Robert G. Torricelli.

Mr. LUGAR. Mr. President, I rise today with my colleague Senator BINGAMAN to re-introduce the Start Healthy, Stay Healthy Act of 2003.

The United States ranks 26th in infant mortality and 21st in maternal mortality in the world, the worst among developed nations. Study after study shows that providing prenatal care to pregnant women reduces maternal and infant mortality and the incidence of low birth weight babies. According to the American Medical Association, ''Babies born to women who do not receive prenatal care are four times more likely to die before their first birthday.''

The Start Healthy, Stay Healthy Act of 2003 would significantly reduce the number of uninsured pregnant women and newborns by providing States with the option to further extend coverage to pregnant women through Medicaid and CHIP, to reduce infant and maternal mortality and low birth weight babies, and to cover newborns through the first full year of life.

Current federal law allows pregnant women to receive coverage through CHIP through age 18—creating a perverse Federal incentive of covering only teenage pregnant women and cutting off that coverage once they turn 19 years of age. This legislation would eliminate this problem by allowing States to cover pregnant women through CHIP, regardless of age. This also eliminates the unfortunate separation between pregnant women and infants that has been created through CHIP, and is contrary to longstanding federal policy through programs such as Medicaid, Women with Infants and Children, WIC, Maternal and Child Health, MCH, etc.

An estimated 4.3 million, or 32 percent, of mothers below 200 percent of poverty are uninsured. According to the March of Dimes, ''Over 95 percent of all uninsured pregnant women could be covered through a combination of aggressive Medicaid outreach, maximizing coverage for young women through [CHIP], and expanding CHIP to cover income-eligible pregnant women regardless of age.''

Increasing the availability of affordable health care is certainly an issue of great importance to our Nation—particularly those who are uninsured. While our bill will not solve the problem of the uninsured, we believe that helping more pregnant women and babies receive care is a significant step in the right direction.

I ask our colleagues to support the Start Healthy, Stay Healthy Act of 2003, and help us take this important step in improving health care for the mothers of tomorrow.

By Mrs. FEINSTEIN (for herself, Mr. SCHUMER, Mr. CHAFEE, Mr. JEFFORDS, Mr. KENNEDY, Mr. DURBIN, Mr. LAUTENBERG, Mrs. BOXER, and Mr. REED):

S. 1034. A bill to repeal the sunset date on the assault weapons ban, to ban the importation of large capacity ammunition feeding devices, and for other purposes; to the Committee on the Judiciary.

Mrs. FEINSTEIN. Mr. President, I rise today to introduce legislation with Senators CHUCK SCHUMER, LINCOLN CHAFEE, BARBARA BOXER, DICK DURBIN, JACK REED, FRANK LAUTENBERG, JIM JEFFORDS, and EDWARD KENNEDY that would permanently reauthorize the assault weapons ban and close the clip-importation loophole.

Military-style assault weapons simply have no place on America's streets. But if Congress fails to act, the current ban will expire next year. This would be a terrible mistake.

This is why Congress must reauthorize the ban and close the high-capacity

clip importation loophole so that we can help keep America's streets safe from the violence produced by assault weapons.

Almost 10 years ago on July 1, 1993 Gian Luigi Ferri walked into 101 California Street in San Francisco carrying two high-capacity TEC–9 assault pistols.

Within minutes, he had murdered eight people, and six others were wounded. This tragedy shook San Francisco and the entire nation.

We saw with absolute clarity the destruction that could be inflicted with these military-style assault weapons.

Navegar's advertising for the TEC–9 touted the gun as being for 'paramilitary' use and 'resistant to fingerprints,' with a 'military non-glare finish,' a 'military blowback system,' and 'combat-type' sights.

Guns like these are the weapons of choice to commit crimes. They are the weapons of choice for drive-by shooters, criminals going into a major criminal event, and malcontents who are seeking to do the maximum damage possible in the shortest amount of time.

That's what makes them so dangerous because they have light triggers, you can spray fire them, you can hold them with two hands, and you don't really need to aim.

They are not weapons of choice for hunting or defensive purposes.

In the aftermath of 101 California and countless other shootings, I decided to do something that no one had succeeded in doing before: to ban the manufacture and importation of military style assault weapons.

I authored the bill in the Senate, and Senator SCHUMER authored it in the House of Representatives.

I remember all the late night calls I got and all the friends who took me aside and said to me: ''Don't do it. The gunners are too powerful. You'll never ever win.''

Well, we did win. We passed the first-ever ban on assault weapons, and since September 13, 1994, it has been illegal to manufacture and import military-style assault weapons.

The hope of the bill has been to drive down the supply of these weapons and make them more expensive to obtain.

And in the years following the enactment of the ban, crimes using assault weapons were reduced dramatically.

In 1993, assault weapons accounted for 8.2 percent of all guns used in crimes; By the end of 1995, that proportion had fallen to 4.3 percent—a dramatic drop; and by November 1996, the last date for which statistics are available, the proportion had fallen to 3.2 percent.

These are dramatic results, which show that the Assault Weapons ban has worked. We have had trouble getting updated statistics from this Justice Department, but it is clear that after we banned these guns, criminals used them less frequently in crime.

Unfortunately, to get the bill passed in 1994, we had to agree to a ten-year sunset in the bill—and this is why we are here today. If we do not re-authorize the 1994 assault weapons ban this Congress, it will expire on September 13, 2004.

That means that at the end of next year, manufacturers could once again begin making AK–47s, TEC–9s, and other banned guns that have but one purpose—to kill other human beings.

We are here today because we believe that this would be a terrible mistake—with deadly consequences for thousands of Americans each year.

So today we will introduce legislation to do two simple things. First, the legislation would reauthorize the 1994 assault weapons ban by striking the sunset date from the original law. This would ban the manufacture of 19 types of common military style assault weapons—for all time.

It would ban an additional group of these assault weapons that have been banned by characteristic for 8 years.

It would protect some 670 hunting and other recreational rifles for use by law-abiding citizens.

And it would preserve the right of police officers and other law enforcement officials to use and obtain newly manufactured semi-automatic assault weapons—helping to prevent instances when law enforcement agents are outgunned by perpetrators.

We certainly would like a stronger bill that would tighten the ban—based on our 10 years of experience of what the gun companies have done to get around the bill.

But unfortunately there is not the support for that right now. If the support becomes evident, then we may amend the bill at a later date.

Second, the legislation would close a loophole in the 1994 law, which prohibits the domestic manufacture of high-capacity ammunition magazines, but allows foreign companies to continue sending them to this country by the millions.

A measure that would have closed this loophole passed the House and Senate in 1999 by wide margins, but got bottled up in a larger conference due to an unrelated provision.

The result: the Bureau of Alcohol, Tobacco and Firearms has approved the importation of almost 50 million high capacity ammunition magazines from some 50 countries since 1994.

It is these large clips, drums, and strips that allow lone gunmen, or small groups of teenagers, to inflict so much damage in such a small amount of time.

We must close this loophole now.

The good news: President Bush has indicated that he supports each of these provisions. During the 2000 Presidential Campaign, President Bush indicated that he supported both reauthorization of the assault weapons ban and closing the clip importation loophole.

And just a few weeks ago, President Bush's spokesman Scott McClellan reiterated his support for reauthorizing the ban when he said: ''The President supports the current law, and he supports reauthorization of the current law.''

It is therefore our hope that the President will work with us to see this bill passed. We welcome the President's support and look forward to working with him to gain swift passage of this legislation.

One of the best examples of the damage that assault weapons can inflict is the massacre in Littleton, Colorado.

On April 24, 1999, Eric Harris and Dylan Klebold used a TEC DC–9 semi-automatic pistol to attack the students and teachers of Columbine High School.

They used this weapon to take the lives of 13 innocents, 12 students and 1 teacher, and injured dozens more mothers, fathers, sons and daughters.

I do not believe that the 2nd Amendment protects military assault weapons. The Constitution is not an umbrella for mayhem. The Bill of Rights is not a guarantor of violence.

Congress has passed this legislation once—it is time to pass the assault weapons ban again.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1034

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Assault Weapons Ban Reauthorization Act of 2003''.

SEC. 2. REPEAL OF SUNSET DATE.

Section 110105 of the Public Safety and Recreational Firearms Use Protection Act (18 U.S.C. 921 note) is amended to read as follows:

''SEC. 110105. EFFECTIVE DATE.

''This subtitle and the amendments made by this subtitle shall take effect on September 13, 1994.''.

SEC. 3. BAN ON IMPORTING LARGE CAPACITY AMMUNITION FEEDING DEVICES.

(a) IN GENERAL.—Section 922(w) of title 18, United States Code, is amended—

(1) in paragraph (1), by striking ''(1) Except as provided in paragraph (2)'' and inserting ''(1)(A) Except as provided in subparagraph (B)'';

(2) in paragraph (2), by striking ''(2) Paragraph (1)'' and inserting ''(B) Subparagraph (A)'';

(3) by inserting before paragraph (3) the following:

''(2) It shall be unlawful for any person to import a large capacity ammunition feeding device.''; and

(4) in paragraph (4)—

(A) by striking ''(1)'' each place it appears and inserting ''(1)(A)''; and

(B) by striking ''(2)'' and inserting ''(1)(B)''.

(b) CONFORMING AMENDMENT.—Section 921(a)(31) of title 18, United States Code, is amended by striking ''manufactured after the date of enactment of the Violent Crime Control and Law Enforcement Act of 1994''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 134—TO AUTHORIZE REPRESENTATION BY THE SENATE LEGAL COUNSEL IN NEWDOW V. EAGEN, ET AL

Mr. FRIST (for himself and Mr. DASCHLE) submitted the following resolution; which was considered and agreed to:

Whereas, S. Res. 343, 107th Congress, authorizes the Senate Legal Counsel to represent the Secretary of the Senate and the Senate Financial Clerk in the case of *Newdow* v. *Eagen, et al.*, Case No. 1:02CV01704, pending in the United States District Court for the District of Columbia;

Whereas, additional defendents have been named in that case; and

Whereas, pursuant to sections 703(a) and 704(a)(1) of the Ethics in Government Act of 1978, 2 U.S.C. §§ 288b(a) and 288c(a)(1), the Senate may direct its counsel to represent officers and employees of the Senate in civil actions with respect to their official responsibilities: Now, therefore, be it *Resolved* That the Senate Legal Counsel is authorized to represent all Senate defendents in the case of *Newdow* v. *Eagen, et al.*

SENATE RESOLUTION 135—EXPRESSING THE SENSE OF THE SENATE THAT CONGRESS SHOULD PROVIDE ADEQUATE FUNDING TO PROTECT THE INTEGRITY OF THE FREDERICK DOUGLASS NATIONAL HISTORIC SITE

Mr. FRIST (for himself and Mr. BROWNBACK, and Mr. TALENT) submitted the following resolution; which was referred to the Committee on Energy and Natural Resources:

S. RES. 135

Whereas Frederick Douglass freed himself from slavery and, through decades of tireless efforts, helped to free millions more;

Whereas as a major stationmaster on the Underground Railroad, Frederick Douglass directly helped hundreds on their way to freedom through his adopted home city of Rochester, New York;

Whereas Frederick Douglass learned to write and do arithmetic on his own initiative;

Whereas as a publisher of the North Star and Frederick Douglass' Paper, Frederick Douglass brought news of the antislavery movement to thousands of people;

Whereas Frederick Douglass helped recruit African-American troops for the Union Army and his personal relationship with Abraham Lincoln helped to persuade the President to make emancipation a cause of the Civil War;

Whereas in 1872, Frederick Douglass moved to Washington, D.C., where he initially served as publisher of the New National Era, intending to carry forward the work of elevating the position of African Americans in the post-emancipation period; and

Whereas Frederick Douglass also served briefly as President of the Freedmen's National Bank and subsequently in various national service positions, including United States Marshal for the District of Columbia and diplomatic positions in Haiti and the Dominican Republic: Now, therefore, be it

Resolved, That it is the sense of the Senate that Congress should provide adequate funding to protect the integrity of the Frederick Douglass National Historic Site.

SENATE RESOLUTION 136—RECOGNIZING THE 140TH ANNIVERSARY OF THE FOUNDING OF THE BROTHERHOOD OF LOCOMOTIVE ENGINEERS, AND CONGRATULATING MEMBERS AND OFFICERS OF THE BROTHERHOOD OF LOCOMOTIVE ENGINEERS FOR THE UNION'S MANY ACHIEVEMENTS

Mr. DASCHLE (for Mr. KENNEDY (for himself and Mr. VOINOVICH)) submitted the following resolution; which was referred to the Committee on the Judiciary:

Whereas the Brotherhood of Locomotive Engineers was founded on May 8, 1863, as a secret, fraternal labor organization and its first meetings were held clandestinely for fear of reprisals from railroad management;

Whereas the climate toward labor organizations at that time was extraordinarily hostile, and many of the other newly founded labor organizations failed to withstand the negative pressures placed upon them and disbanded in their infancies;

Whereas the Brotherhood of Locomotive Engineers began to thrive despite the climate into which it was born;

Whereas the Brotherhood of Locomotive Engineers has grown from its original 13 members, all from the Michigan Central Railroad, to 59,000 active and retired members employed throughout the United States and Canada;

Whereas the Brotherhood of Locomotive Engineers is North America's oldest rail labor union;

Whereas the Brotherhood of Locomotive Engineers' members have contributed, both directly through their railroad activity and in private capacities, to the war effort in all of the battles of the United States dating back to the Civil War;

Whereas their efforts to improve rail safety for both their members and the public have resulted in a dramatic decrease in the number of railroad accidents in the years since their inception;

Whereas in 1964, the Brotherhood of Locomotive Engineers launched an apprentice engineer program to assure the Nation of a stable supply of well-trained locomotive engineers, and to assure stable employment and earnings to apprentices;

Whereas after accepting only promoted locomotive engineers in its early years, the Brotherhood of Locomotive Engineers enlarged its membership goals to include other rail employees;

Whereas in 1993, the 2,500 member American Train Dispatchers Association officially affiliated with the Brotherhood of Locomotive Engineers in order to unite the two key railway professions that facilitate the efficient and safe movement of passengers and freight;

Whereas in 1995, the Rail Canada Traffic Controllers union also chose to merge into the Brotherhood of Locomotive Engineers, adding another 700 members;

Whereas in addition to providing representation for its members, the Brotherhood of Locomotive Engineers aggressively participates in the labor movement with other unions and organizations in promoting the interests of working men and women and their families;

Whereas the Brotherhood of Locomotive Engineers is an extraordinary union whose leadership still works hard every day—just as it did in 1863—to protect members' health and safety, to guard their financial interests, to give them an effective voice on the job, and to ensure dignity, respect, and security for railway workers in the workplace; and

Whereas the efforts of the Brotherhood of Locomotive Engineers are deserving of our attention and admiration: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the union which has made a tremendous contribution to the structural development and building of the United States, and to the well-being of tens of thousands of workers;

(2) congratulates the union for its many achievements and the strength of its members; and

(3) expects that the union will continue its dedicated work and will have an even greater impact in the 21st century and beyond, and will enhance the standard of living and working environment for rail workers and other laborers in generations to come.

SENATE RESOLUTION 137—HONORING JAMES A JOHNSON, CHAIRMAN OF THE BOARD OF TRUSTEES OF THE JOHN F. KENNEDY CENTER FOR THE PERFORMING ARTS

Mr. FRIST (for himself, Mr. DASCHLE, Mr. STEVENS, Mr. KENNEDY, Mr. JEFFORDS, Mr. INHOFE, Mrs. HUTCHISON, and Mrs. FEINSTEIN) submitted the following resolution; which was considered and agreed to:

Whereas James A. Johnson has served with distinction since 1996 as the Chairman of the Board of Trustees of the John F. Kennedy Center for the Performing Arts, which is the national center for the performing arts;

Whereas under the leadership of Jim Johnson, the Kennedy Center has earned impressive renown, and become one of the finest performing arts institutions in the Nation and around the world;

Whereas Jim Johnson initiated free public performances each evening on the Millennium Stage at the Kennedy Center, and these performances have now included a total of 25,000 performers and reached an audience of 1,500,000 persons since 1997;

Whereas the arts education programs of the Kennedy Center have been significantly expanded under the inspired leadership of Jim Johnson;

Whereas Jim Johnson has launched a major renovation and construction project to improve the physical structure of the Kennedy Center and enrich the experience of all who visit and attend performances; and

Whereas Jim Johnson deserves the thanks of a grateful Nation for his leadership at the Kennedy Center, and in bringing new vitality to the cultural heritage of our Nation: Now, therefore, be it

Resolved, That the Senate—

(1) expresses its appreciation for all that Jim Johnson has accomplished; and

(2) commends Jim Johnson for his extraordinary achievements as Chairman of the John F. Kennedy Center for the Performing Arts.

AMENDMENTS SUBMITTED & PROPOSED

SA 536. Mr. FEINGOLD proposed an amendment to the bill S. 113, to amend the Foreign Intelligence Surveillance Act of 1978 to cover individuals, other than United States persons, who engage in international terrorism without affiliation with an international terrorist group.

SA 537. Mrs. FEINSTEIN (for herself, Mr. ROCKEFELLER, Mr. LEAHY, Mr. EDWARDS, Mr. FEINGOLD, Mr. DODD, Mr. WYDEN, and Mrs. BOXER) proposed an amendment to the bill S. 113, supra.